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ORIGINAL ARTICLES.

FEVER NOTES.

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IT is not many years since there was a lively discussion in regard to the unity, duality, or plurality of some of the essential fevers, which, to most students of the present day, seems to be finally settled against the advocates of unity. *Conclusum est*, they would say, leaving no rational basis for argument. But granted that the dualists or pluralists have the right of it, there is often room in the mind of the practitioner for "obstinate questionings" as to what category the fever under treatment may properly come. Fever is undoubtedly more or less protean in shapes, and one form may merge into another, as, *e. g.*, to-day remittent, and to-morrow yellow; but it has common characters enough to entitle it to consideration independently of its varieties.

A great American authority of the last century says: "I shall not attempt to give a definition of fever. It appears in so many different forms that a just view of it can only be given in a minute detail of all its symptoms and states." (B. Rush.)

The American Medical Association attempts pretty successfully what Rush declines, thus: "Fever, *febris*, an acute affection of the system, with increased heat and derangement of all the functions."

Fever is then a very unquestionable entity, and the family likewise is so marked in its varieties as not unfrequently to cause difficulties in diagnosis or nomenclature:

"*Facies non omnibus una, nec diversa tamen qualem debet esse sororum*," and, until science makes the living body quite transparent, some allowance may be made for the doctor's occasionally confounding congestive remittent with yellow fever, typhus with typhoid, or typhoid with acute tuberculosis. Any one may merge into the other.

Diseases will often deviate from the types so clearly laid down in the text-books; in fact, a real typical case agreeing throughout with its classical description is something of a rarity.

I saw but the other day some eight or ten cases of measles, where the eruption was not only measly, but purplish. The visitation was among boys picked up from the streets, poor, homeless little vagrants, who were taken to a house of charity, where they were to be taught useful trades, reading and writing and the catechism. The attending physician, Dr. Goldsmith, reported out of twenty-one cases taken ten deaths, and more in prospect. There was absolute adynamia, with rapid prostration, red and dry tongue, congested fauces, temperature, when exceeding 105° F., always indicating a fatal result, which occurred notwithstanding the liberal use of quinine and whiskey. Who ever sees such measles in ordinary practice?

I thought there was here a remarkable resemblance to typhus which I had seen some years previously in the same institution. Dr. John Morris, who saw these cases, remarked to me on the following day, that their whole condition and aspect reminded him of the Irish typhus as he had seen it in the Dublin Hospitals. Now, this predominance of typh-symptoms was due to over-crowding aided by sewer-gas. Tents were immediately procured for the sick, and improvement was immediate.

Thus, modifying circumstances, as ochlesis, may give to every fever quite a change of type or form. Our once great authority, Rush, says, "There is but one fever," no matter what its source, cause, or development; "we might as well say that men are of different species because they are tall or short, or because some are long and others short-lived, as that fevers are of different species because they vary in their symptoms and duration." We need not accept such view to make the assertion that fever has certain unities never obliterated by its forms, and that some of these defy strict nosological arrangement. I have frequently had to treat continued fevers that did not correspond textually with any one of the three predominant forms, typhus, typhoid, or typho-malarial.

In 1879 I attended many cases of continued fever in this city, which had some peculiar characters, and of which I gave a brief verbal account at a meeting of the Baltimore Academy of Medicine. The reporter (*Maryland Medical Journal*), following my language pretty closely, says, "Dr. McSherry spoke of the so-called typho-malarial fever. It is not distinctly typhoid, nor typhus, nor malarial, though doubtless there is in it a malarial element. He should be disposed to call it 'typh-fever,' after Chambers. Quinine will not break it up. A remarkable feature about it is the disproportion in the pulse and temperature. For instance, in one case the temperature was 103° F. while the pulse was 80, and this relation continued for about three weeks. Once the pulse went up to 108, but the temperature then was 107° F. With such a temperature as this we should have a right to look for a pulse of about 160. The patient recovered. He had heard of a case in which the temperature rose to 109° F., with a fatal result. In the case of a medical student, æt. 24, when first seen the temperature was 102° F., the pulse 92; the next morning they were respectively 105° F. and 86. The highest pulse-beat at any time was 96, the temperature being at the same time 104.1° F. He read from a letter just received from Prof. Bartholow, of Philadelphia, in reply to some inquiry upon the subject. Prof. Bartholow said that he had seen

many such cases in Cincinnati, and that the disease was there called typho-malarial fever. He had obtained the best results from the following:

"℞.—Tinct. iodin.,
Acid. carbolici, partes equales.
S.—Gtt. j-ji quartâ vel sextâ quaquâ horâ.

"Quinine, he says, does nothing more than reduce the pyrexia. When diarrhœa occurred he used liq. potass. arsenical. gtt. j and tinct. op. deod. gtt. ij-v every four hours.

"Dr. McSherry thought quinine was wantonly wasted under German authority," etc.

I will recur to the use or misuse of this potent agent a little later.

Several other members of the Academy reported at different sittings, cases more or less resembling those. Thus in Dr. McKew's experience: "It is a continued fever lasting five or six weeks, with somewhat erratic thermometric phenomena, no diarrhœa as a rule, no rose spots, no intellectual impairment, no involvement of the pulmonary mucous membrane, no tenderness in the iliac regions, tongue free from typhoid characters. One case exhibited very obstinate constipation."

Dr. Thomas, Dr. Van Bibber, Dr. Williams, and Dr. O'Donovan gave accounts of their fever cases. Dr. Thomas considered his to be typho-malarial; not so Dr. McKew, who said "there was nothing of the typhoid character in it except continued fever. It is a zymotic poison, the nature of which is entirely unknown."

As the world is very intolerant of nameless diseases, we may call such cases typho-malarial in our daily rounds, conventionally, whatever may be said of them in medical discussions.

Malarial fevers proper are pretty uniformly held to be *intermittent* or *remittent*, but they may be *continued*, at least, without any typhous complication. A very excellent paper on this subject, under the title of "Fevers of the Mississippi Valley," appeared in the AMERICAN JOURNAL OF THE MEDICAL SCIENCES (April, 1881), from the pen of Dr. R. B. Maury, of Memphis.

The malarial continued fever is not to be confounded with the bilious remittent, which, as Dr. Maury says, has a natural tendency to defervesce on the fifth day, may be terminated on the third, and only in exceptional cases will last until the seventh or ninth day.

The malarial continued, on the other hand, "presents a stadium of increase of about one week, a stadium of height of about five or six days, and a stadium of decrease, which terminates completely on the twenty-first day."

Is this typho-malarial fever? By no means, though often so designated.

"Its thermometric range is decidedly lower than that of typhoid. It seldom goes above 103.5° F. Vomiting of bile is a common symptom during the first days of the attack. Bronchial catarrh is generally present. Constipation and a concave abdomen are marked features."

Appreciable splenic dulness or enlargement was very rarely observed.

"All the essential features of typhoid or enteric fever are absent. There is no diarrhœa, no ileo-cæcal tenderness or gurgling, no meteorism, no eruption of rose-colored spots. As a rule, there is entire absence of abdominal symptoms."

This form begins, continues, and ends, says Dr. Maury, as a continued fever. It is somewhat notable that he declares "its duration to be in no way affected by the exhibition of antiperiodic remedies. The 'status typhosus' is not one of its characteristics. When it occurs it is exceptional, and is due to extraneous causes. The abdominal symptoms are absent, hence there would seem to be no relation to typhoid."

Some of our Baltimore cases correspond pretty much with those reported by Dr. Maury. I do not observe in them, however, any irregular relations between pulse and temperature, as noticed in this city and elsewhere, in our continued fevers, however they may be designated.

Prof. Johnston, of Washington City, describes some cases of mild continued fever which prevailed in that community (AMERICAN JOURNAL OF THE MEDICAL SCIENCES, October, 1882). In his view such cases are truly typhoid, however imperfect the development. He gives an illustrative case of continued fever without typhoid symptoms for sixteen days, after which the patient was taken unexpectedly with "vomiting and violent pain in the abdomen, which soon became tense and painful; he was restless and very thirsty. The temperature had risen to 104° F., and continued to rise, and the pulse was 154. During the day he sank into collapse, with cold sweats, and died at 10 A.M. on the following day. The diagnosis of typhoid fever was justified by symptoms pointing clearly to intestinal perforation."

We suspect that Dr. Woodward would have had no hesitation in calling this an attack of typho-malarial fever.

It may be noted, *en passant*, that Dr. Johnston, in speaking of the influence of quinine upon his cases, says, "It lowers the temperature, but does not arrest the disease."

What must we think of this continued fever that in so many experiences resists quinine? It is not typhus, but is it malarial, typho-malarial, or typhoid? Or none of these, but one *sui generis*? The fact is, that with all our efforts at precision, and with all our attempts to confine a disease in a nosological strait-jacket, it will not be so restrained, for the simple reason that it rarely arises from a single cause, or if the cause be single, as some one miasm, contagium, bacillus, or germ, there are always modifying conditions to change its nature, as in the measles presented in the early part of this paper.

The medical sagacity which never makes mistakes in diagnosis, considering the liability to changes of form in most maladies, is rarely quite trustworthy. Yellow fever, for example, may come on as a remittent—indeed it is usually a remittent—the remission occurring, according to Sternberg, on the third, fifth, seventh, or ninth day; just as Maury says of the Mississippi remittents: "This fever often terminates on the third day; as a rule,

it subsides on the fifth day. In the fall, it is occasionally prolonged until the seventh, and I have seen it prolonged to the ninth day."

Are not such observations very suggestive? I myself have seen corroboration of the following statement made by the late Dr. Fenner, of New Orleans:

"Physicians may say what they please about being able to distinguish a case of yellow fever as soon as they examine it. We do not believe it possible according to their ideas. Rarely does a summer pass in which we do not hear of some intelligent and experienced practitioner being perfectly astonished at what he had pronounced a case of intermittent or remittent fever terminate in black vomit or other hemorrhage."

Besides the cases of my earlier experience in the tropics, and subsequently among cases coming hither from Norfolk and Portsmouth, in 1855, I have seen an isolated case much more recently in which the patient was attacked, as I learned upon sufficient authority, with a remittent form of fever six days before his death. Under the influence of quinine, the fever remitted, but, before his death, the patient became quite yellow, and passed, while unconscious, bloody urine in bed. Urine drawn when dying gave no blood or albumen, but there was a pretty lively fermentation when nitric acid was added. I saw him only in this condition, and remarked then that I had seen similar cases in which black vomit was found in the stomach *post mortem*, though none had been ejected. And so it turned out. Upon examination of the viscera, the lungs showed at the base hypostatic congestion; the heart was soft, as in low fevers; the liver very small and anæmic; the kidneys congested, and showing various hemorrhagic spots of rupture or exudation. The bowels were congested. The mucous membrane of the stomach was somewhat eroded, and there were perhaps eight ounces of what would surely have been called in Vera Cruz *vomito prieto*, though, it being an isolated case, the physicians did not think it advisable to publish it as yellow fever. [I have since learned indirectly that, notwithstanding the macroscopic resemblances to yellow fever, the microscopic examinations subsequently made gave results tending to show that very rare disease, acute yellow—or I should rather say *red*—atrophy of the liver.]

Dr. Rush says the physicians of Philadelphia had thirteen different names for yellow fever as it appeared there under his observation.

Now that Dr. Carmona, of Mexico, has found a yellow fever fungus as distinct as Koch's bacillus tuberculosis, perhaps modern pathologists may find a ready solution of all doubts in regard to the diagnosis of this particular fever. Perhaps they will; more probably they will not. The world teems with germs, no doubt, that are destroying agents, or potentialities, but it will be a long time before their exact relations are understood to the disease with which they are found associated. Every thing about us perishable, or all that "wears the muddy vesture of decay" seems to have a being prepared to consume it. One low creature may find its nidus and food in tubercle, another in the white corpuscles of the vitiated blood of eruptive fevers; and there be saprophytes for the last consumption of decayed organic matter, but these are consumers, not producers. Many pernicious bacteria, we must believe, carry infection, which is rather *adherent* than *inherent* in their natures.

In the treatment of our fevers until we learn to cure them all by germicide agents, and allow our patients to die of nothing but accident, or old age, we must consider how best to use the two opposite classes of reconstructive and spoliative remedies, which may be fairly represented by cinchona bark, mercury, and bloodletting.

Such are potent agents for good and for evil; we wish to get from them the most of the one and the least of the other. The bark (quinine) is antidotal to malaria, tonic in small doses, sedative in large doses. By some property (germicidal?) it neutralizes the poison of malaria; it helps to build up the debilitated subject; it is competent to reduce temperature. These are obvious influences. Perhaps, when properly used, it is the best drug in the materia medica. But it is not, therefore, a panacea. Such agent does not exist in medicine. Granted its potency against the direct pernicious influence of malaria, it is not of peculiar efficacy against secondary lesions. It no more removes the after-effects of the poison than the antidotal chalybeates would cure gastritis or other secondary effects from arsenical poisoning.

Many of its partisans place in it too exclusive a trust. I have many times given it day after day in all kinds of doses when fever was yielding, but with unmitigated malaise on the part of the patient until some mild mercurial would be given for a few days, when, *presto*, the patient would improve in every sense. In the case of a lady now under treatment, suffering with malarial malaise, quinine offended the stomach and impaired the appetite until a few fractional doses of calomel came to the rescue and gave much relief.

In the various cases and conditions previously referred to in this paper, quinine, whether useful or not, was inadequate to cure. It was given freely in the typhous measles with whiskey, without preventing the fatal issue.

It appears to the writer that there is a great waste of this valuable agent of late years as, *e. g.*, when given in large doses for the reduction of temperature, when so many other medicines, to say nothing of ice or cold water, answer such purpose quite as well, if not better.

But it may prove a mischievous agent withal. Dr. W. O. Baldwin, of Montgomery, Ala., has published observations upon this subject; and showing such facts more recently, a paper published in THE MEDICAL NEWS of July 21, 1883, from the pen of Dr. E. D. McDaniel, of Camden, Ala., gives confirmation to such views.

Dr. McDaniel reports eighteen cases of hemorrhagic malarial fever in his own practice, in which there were thirteen recoveries and five deaths. It is very significant that in six cases in which no quinine was used the result is stated thus: "In the six

cases without quinine six recoveries, or 100 per cent."

Whereas, it is also stated, "In twelve cases with quinine five deaths, or 41.66 per cent."

Besides these eighteen, Dr. McDaniel saw six other cases in consultation. He had given all of his own small doses of calomel, with or without quinine. In regard to these six, he says that calomel was used in larger doses, and quinine and spirit of turpentine were freely given. The result was five deaths and one recovery.

It is by no means easy always to appreciate cause and effect in medicine, but if these cases had all been treated *à la* Rush, with the free use of the lancet, the unfortunate result would have been attributed directly to that agency. Physicians still have something to learn as to the proper use of quinine and bloodletting; the one, according to the fashion of the day, being too much used, and the other too much neglected. May it not be safer to reduce fever by the abstraction of a few ounces of blood than by drugging the whole mass of it as it circulates through every viscus and tissue of the animal economy?

Let us bring quinine to its right and proper uses, and reserve it for such purposes.

As to eliminants in fevers they do not play an inferior part, except in counteracting the first effects of malaria.

The observers of the last century were not men to have eyes and see not, as the men of to-day seem to suppose. It is true our eyes are aided by the microscope and other instruments of precision, but our fathers had good-sense and good senses, and made good use of their gifts.

"Sir John Pringle," says Rush, "long ago taught the inefficacy of bark in certain bilious fevers. But Dr. Chisolm has done great service to medicine by recording its effects in the Boulam fever. 'Headache,' says the doctor, 'a heavy, dull eye, with a considerable protrusion from its orbit, low spirits, thirst, and a total want of appetite, were the general consequence of the treatment with bark without the previous antiphlogistic.'"

I know not what particular antiphlogistic was preferred in these cases, but I am quite sure that a vomit and a purge (say with ipecacuanha and calomel) in the beginning generally render efficient service. I do not doubt that Warburg's tincture, which so often does good when bark has failed, has its good effect by elimination, and just such elimination as may be obtained from mercury and aloes.

Dr. Murchison would sustain this view. Mercury, in his opinion, "exerts a beneficial action in many functional derangements of the liver, in whatever way this may be explained. Patients of the greatest intelligence, suffering from hepatic disorders, constantly declare that they derive benefit from occasional or repeated doses of mercurials which no other medicine or treatment confers; and the scepticism of the most doubting physician would, I believe, be removed should he unfortunately find it necessary to test the truth of their statement in his own person." (*Croonian Lectures.*)

And what fever is known in which there is not functional derangement of the liver? This same authority further remarks, touching such derangements resulting in lithæmia, "I have repeatedly known patients in this state improve at once on substituting abstinence from alcohol with aperients, blue pill, alkalies, and careful regulation of diet, for quinine, iron, the mineral acids, and stimulants; the strength, flesh, and color returning under what, at first sight, might have appeared a lowering treatment." I have often seen similar beneficial results from such change of management in many other morbid conditions as well as in lithæmia.

A medical address was sent to me some months since entitled "Fifty Years Ago," by Prof. Henry Gibbons, M.D., of San Francisco, which offers some interesting reminiscences as to the early use of quinine, *inter alia*, in this country. The white powder was brought from France, and "people were greatly astonished that eight grains of it should do the work of an ounce of bark, that is, arrest or break an intermittent. It was given with great caution. From eight to ten grains was the limited quantity. According to my recollection, the dose was more decidedly and permanently effectual than the large doses now employed. But the older doctors always prepared their patients first by a mercurial purge, or a few blue pills. They had an eye to the condition of the liver and spleen, and other organs which suffer from malarial diseases. Their practice in this respect might well be imitated by the present generation of practitioners, who too generally depend altogether on the one remedy in the treatment of intermittent fever."

The profession has become too much afraid of depletion, and has taken to depend too much upon quinine, tonics, and nervines. I attended a lady lately who has been a martyr to nervous headaches for years. A few small doses of mercury gave her more relief than any remedy she had previously taken.

I was called some months ago to a lady of full habit, whose flushed face, full pulse, and headache gave indications of cerebral disorder, perhaps of apoplexy. She was attended by an intelligent physician who had drugged her freely and had had her cupped on the back of the neck. I advised venesection, to which the doctor assented, and I drew from her arm about sixteen ounces of blood. Relief was prompt and, so far, permanent, for she has since been in better condition than for a long time previously.

We underrate the intelligence of our fathers when we pronounce that their bleeding and purging were all bad practice. That there was a great deal of bad practice in the abuse of such agencies may be freely admitted; but if we drop out of use all medicines capable of doing harm when misused, I know not what would be left, not even excepting chloride of sodium. Now, as of old, according to Ovid, *Nil prodest quod non possit lædere idem.*

The mercurial chlorides which had such vogue among the physicians a few decades back would not have commanded such universal confidence without some reasonable justification. Perhaps they will become rehabilitated in professional estimation

as the germ theory advances, for, like quinine, they too are potent germicides, and it may be that a large part of their efficacy was due to this power, which was and is real, whether appreciated or not.

Be that as it may, I beg leave to declare, as the result of no small experience of my own, as well as that cited from others, that there is at this day too great reliance upon bark (quinine) to the neglect of depleting agents in fever; that quinine is not only wasted, but that it is used extravagantly, and even injuriously, and that *less* of it will accomplish a better purpose than *more*, when used with eliminants, always discreetly, of course, whether the agents be bloodletting, vomiting, or purging. An old-fashioned nitrous powder, or a few drops of Fleming's tincture of aconite, judiciously administered, will reduce fever more effectively than quinine, and then that transcendent agent may be used for purposes which no known medicine can equally well accomplish.

BALTIMORE, August, 1883.

ON THE VALUE OF IODINE IN MALARIA.

BY FRANK FINNEY, M.D.,
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IN view of the elaborate and carefully written article of Drs. Atkinson and Woods in the July number of THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES on the use of iodine in malarial fevers, and an editorial in THE MEDICAL NEWS of July 7th on the same subject, I feel called upon to give a brief account of thirteen cases of malarial fever treated by me during September and October, 1882, which very strongly coincide with the experience given in the above-named article. The treatment of my cases differed slightly from the above mentioned, since in all of them I used iodine in combination with carbolic acid, as advocated in the editorial referred to. The combination I used was tincture of iodine one ounce, glycerite of carbolic acid one drachm. This mixture I gave to adults in fifteen to twenty-drop doses four times a day, reducing the dose in proportion to the age of the patient.

CASE I.—Female, age two years; quotidian intermittent; had been sick one week when I was called; gave castor-oil cathartic, and followed with the iodine mixture, four drops in water four times daily. The child recovered, after having two more slight chills, with no other treatment.

CASE II.—Male, age 13, quotidian intermittent; gave a cathartic, and followed with iodine mixture, fifteen drops four times a day. He had one slight chill, followed by temperature of 101°, after beginning the treatment, and then recovery was complete.

CASE III.—Male, age 20, tertian intermittent; treatment same as Case II., with complete recovery without a second chill.

CASE IV.—Male, age 50, quotidian intermittent; gave the mixture in twenty-drop doses four times daily for seven days without any improvement, when it was abandoned, and quinine given with almost immediate success.

CASE V.—Male, age 10, quotidian intermittent; gave eight drops four times a day, with gradual improvement in all of the symptoms, until the fourth day, when vomiting and diarrhœa set in. By the sixth day, these symptoms were so severe that the iodine had to be abandoned. I then gave bismuth and morphine, followed by quinine, with success.

CASE VI.—Female, age 8; treatment and result same as Case V.

CASES VII. and VIII.—Adult males, treated for quotidian intermittent for seven days with fifteen to twenty drop doses of the iodine mixture, without improvement. Quinine was then substituted with success.

CASE IX.—Female, age 5, suffering from chronic malaria; chills every third day. Gave five drops of the iodine mixture four times a day, with iodine tincture externally over the enlarged spleen. The result was gradual recovery after severe jaundice.

CASES X., XI., XII., XIII. were all adults suffering from acute quotidian intermittent fever, and were treated with the iodine mixture in fifteen to twenty drop doses four times daily. Nausea and vomiting became troublesome in Cases X. and XI. on the fourth and fifth days, and it was abandoned. The iodine treatment was kept up for six days in XII. and XIII. with no improvement, when quinine was substituted with the usual success.

It appears from the above notes that *four* out of the thirteen cases treated recovered under the iodine treatment, while the large majority of *nine* had to have the usual quinine treatment before the disease could be controlled.

THE ELECTRO-MAGNET IN THE EXTRACTION OF FOREIGN BODIES FROM THE EYE.

BY OLAF PAGE, M.D.,
OF VALPARAISO, CHILI.,

ON the 10th of July a workman from one of the large foundries in the city presented himself at my consulting-room. He said a piece of iron had struck him in the left eye. On removing the bandage I found a clean cut through the lower eyelid about one-eighth inch long, and another equally clean cut through the sclerotic and lower third of the cornea and iris. A clot of blood completely filled up the pupil. Having procured an assistant, I connected the magnet with a Stöhrer's battery of twenty cells, and applied the point of the magnet to the wound. I immediately heard the clicking of the foreign body against the magnet, but on attempting to draw it out, it fell back into the eye. This I did three or four times, but finding the iron could not come through the linear cut, I got the assistant to hold the point of the magnet in the wound, and then, with a pair of iris-forceps, I was enabled to lay hold of the iron and literally drag it out. The fragment, on weighing, proved to be a trifle over eight grains. It was bayonet-shaped, with sharp, serrated edges.

In cases of this kind I believe ivory forceps would be found very useful in connection with the electric magnet.

MEDICAL PROGRESS.

CANCER OF THE RECTUM; SCRAPING WITH SIMON'S SPOON; RELIEF FOR THIRTEEN MONTHS.—DR. J. CRAWFORD RENTON reports the case of a man, æt. 40, who had been suffering for six months from pain in the lower bowel, accompanied at times by considerable bleeding. On examination, the rectum was found filled with irregular hard masses, which passed for four inches up the bowel, commencing immediately above the anus; behind the urethra they were very extensive and closely attached to it, so that, anteriorly, it was difficult to separate them, they bled easily, and were evidently villous in character. Owing to their urethral attachment, he decided to operate by scraping the surface of the new growth, and not excising the rectum. He therefore scraped away a large number of the masses with the spoon. The urethra was closely involved with them, so that it would have been hazardous to its safety to have removed the rectum. The amount of bleeding was less than he expected, and was easily controlled by finely powdered matico. Chloride of zinc was freely applied to the raw surfaces previous to the introduction of the matico on lint. In forty-eight hours the lint was removed and the rectum washed out with weak Condy's fluid and water; and the following day the patient had a movement of the bowels without any trace of bleeding, the first time for four months that it and pain had been absent. He progressed favorably, and was sent home in a fortnight from the time of operation, and was ordered to take Chian turpentine internally. Since then he has continued free from pain and hemorrhage, and as a consequence looks much stronger. The bowel, when examined early in January of this year, showed that whatever growth had taken place had been slight. The patient declared that he felt great benefit from the Chian turpentine.

The great success attending the late Prof. Simon's operations on the womb in cancer led him to adopt a similar treatment in the above case; and he thinks that although we cannot expect any permanent benefit from it, if we can arrest hemorrhage and relieve pain for a few months by means of it we are entitled to do so. The masses removed were carefully examined and showed appearances characteristic of scirrhus.—*Glasgow Medical Journal*, Sept. 1883.

REMOVAL OF HYDATID TUMOR FROM UNDER SURFACE OF LIVER DURING PREGNANCY.—MR. F. C. BATCHELOR reports the following case: Woman, æt. 34; five children. About a year ago she began to suffer from severe pains in the right side, about the region of the liver. Three months later she consulted the reporter, who found a hard, irregular, solid-feeling tumor, about the size of a kidney, deep in the right lumbar region; it was movable, and could be dragged into the middle line, but returned on discontinuing traction. It descended somewhat on inspiration, and was covered in front by the colon. According to the patient's account, it was increasing rapidly in size. It was painful to the touch, and there were aching, shooting pains through it which kept the patient from sleep at night. Menstruation had been missed for three periods. Careful vaginal examination revealed a retroverted uterus, thought to be in the third month of pregnancy. From the history of the tumor, its hard, irregular feel, and the loss of flesh and pain, the diagnosis seemed to rest between a cancerous growth and a caseous gland. From its increasing size, it was determined not to delay operative measures on account of pregnancy. The abdomen was opened under Listerian precautions. The tumor was found to be an extremely thick-walled, irregular hydatid cyst growing out from the under surface of the liver. The cyst was drawn through the incision, and laid freely open, the delicate, lining membrane removed, and the sac well sponged out with a 1 in 20 carbolic solution. The cyst was separated from the adherent omentum with the finger-nail, and finally cut off level with the liver-substance. There was no bleeding of consequence. The wound healed by first intention, and only required one dressing. There was no constitutional disturbance whatever, and the patient was able to leave her bed in less than a fortnight. Pregnancy ran its natural course, and she was safely delivered.—*Australian Med. Journal*, June 15, 1883.

SALICYLATE OF SODA IN PHLEGMASIA ALBA DOLENS.—M. VIGAR states that he has attended four cases of this affection. In the first he used no internal remedies, limiting himself to the local measures advised by various authors, keeping the patient in bed two months, and even then a certain degree of œdema remained, with a few nodosities on the course of the inflamed veins; these disappeared very slowly, and at the end of five months slight traces of them were still discoverable.

In his other three cases he used the salicylate of soda, with very good results. He gave it to the extent of one drachm per day, and after the first day found that the temperature fell very decidedly, the pulse became slower, and the œdema diminished to a very notable extent; the disease passed through its phases of inflammation and repair in so short a time that not one of the three patients was confined to bed longer than the third week. No signs of œdema or of nodosities on the limb remained.—*Glasgow Medical Journal*, Sept. 1883.

DIMINUTION OF UREA IN CANCER.—DR. W. ROMMELAÈRE, publishes a series of clinical observations illustrating a new fact in the pathology of cancer. He finds, in thirty-four cases, that in persons subject to cancer, the amount of urea daily eliminated progressively diminishes until it is below ʒiij. By studying the urea eliminated in cases, for example, where doubt exists between gastric ulcer and cancer, a diagnosis can be made. In twelve cases of ulcer of the stomach, the daily amount of urea eliminated was about ʒvj.—*Medical Record*, September 15, 1883.

QUEBRACHO IN DYSPNŒA.—DR. MARIANI, from recent experimental and clinical studies of the action of quebracho, draws the following conclusions:

1. Quebracho is a medicine whose principal effects are shown by a diminution of the number of the respirations and cardiac contractions.

2. Its action seems to be especially concentrated on the circulatory centre, on which it has a tonic action in regulating the contractions, either directly or by the intermediation of the nervous system.

3. Quebracho may be considered as the only medicine which has a manifest antidyspnœa. It combats the dyspnœic symptom alone, and without the aid of other medicines.

4. It is highly probable that the symptomatic dyspnœa of acute affections of the thoracic organs may be amenable to quebracho.—*Journal de Med. de Paris*, August 25, 1883.

MOLLUSCUM CONTAGIOSUM.—MODRZEJEWSKI reports one of the most curious and interesting cases of this affection on record. The tumors numbered more than three thousand, varying in size from that of a pea to that of a child's head. M. inclines to the opinion of Recklinghausen, who considers these tumors of the skin as neuro-fibromata, and therefore calls the affection neuro-fibromatosis.—*Gaz. Hebdom.*, Aug. 24, 1883.

THE MEDICAL NEWS.

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SATURDAY, SEPTEMBER 22, 1883.

THE FEVER AT RYE BEACH—SEPTIC OR TYPHOID?

IN a previous editorial on "Sanitary Sins at Rye Beach," we explained the local conditions producing a form of fever at that place. We have now to consider the fever, and ascertain, if we can, the nature of this morbid complexus. Is it septic or typhoid? That we may not be misunderstood, the sense in which we employ these terms must be defined. By *septic*, we mean a form of fever produced by decomposing organic matter received into the system of man. Decomposing organic matter, in contact with the solids and fluids of the body, sets up a change at the points of impact, which gradually extends, until widespread alterations ensue, and a febrile condition is established. Probably we should say, *not all, but some kinds of organic matter* are capable of inducing this process of change. It is to this morbid process that we venture to apply the phrase—*septic fever*.

On the other hand, the disease known as *typhoid fever* derives its existence from a germ, a microbe, an organism. Although this object has not been demonstrated, the facts warrant us in assuming its existence, and hence it can be affirmed that, without the presence of the typhoid germ, there can be no typhoid fever. Is the fever at Rye septic or typhoid? Can the presence of a typhoid germ be predicated on any facts in the disease history of the place? Has the fever at Rye the clinical characteristics of typhoid? We can answer both of the latter questions in the negative.

In respect to the development of fever at one point, but two of the cottages are concerned—one new, and occupied for the first time; and the other six years old, standing within forty feet of the former. The first cottage was occupied by a family free from illnesses of any kind, and a careful investigation has demonstrated that there had been no cases of fever in the other family during the six years of their residence. The occupants of the beautiful new cottage, admirably equipped in every way, except in respect to the pollution of the water-supply, could not, then, have received typhoid germs, although they were unfortunately made to imbibe decomposing organic matter. The water-supply of other boarding-houses in which cases of fever occurred may or may not have been free from typhoid contamination. We are thus able to eliminate typhoid germs as a cause of the fever in the case of the occupants of the new cottage. We are absolutely certain that the water-supply contained a large quantity of organic matter—animal matter in a process of decomposition.

The clinical characteristics of the fever in the cottages have a special diagnostic value in view of the absence of any source whence typhoid poison could have reached the inmates. Without entering into minute details of the differentiation, certain broad marks of difference may be readily stated. The prodrome consisted in the state known as *malaise*, and did not differ from typhoid except in the irregularity of its development. Instead of a gradual increase in the severity of the symptoms, there were periods of apparent restoration to health, of variable duration, so that the progress made was in a succession of leaps. There can be no formulated statement made of the temperature when the disease was fully developed. In other words, the temperature-curve followed no definite law. There were no regular periods of exacerbation and remission, and during the apparent maximum of the fever, a decline of temperature, sufficiently rapid to be like a "lysis," would occur, and for several days the normal thermal line would be established. During the protracted evolution of some cases, there occurred several of these apparent attempts at convalescence, so that the course of the fever was made up of a succession of relapses. It would be mere supererogation to point out the fundamental differences in the thermal range of this fever and that which is so characteristic of typhoid.

In respect to the nervous symptoms, the differences between these fevers were even more marked. In the cottage cases at Rye there was a more or less profound adynamia, but no stupor, no delirium, nothing of *coma-vigil*. The slowness of intellection observed was that of cerebral anæmia, and was not comparable to the mental hebetude, the low muttering delirium, and the coma of typhoid.

There was no eruption—none of the rose spots of typhoid; but in one case there were large vibices

on the sacrum and on the great trochanter. The formation of these occurred at the time of greatest depression, and were coincident with more or less bleeding at the nose and gums. The condition of the blood—probably, for there were no means available at that place for its proper investigation—was the chief element in the morbid complexus.

Complete anorexia—an absolute loathing of food, indeed—the tongue heavily coated, and the breath fetid, were usual symptoms. Diarrhœa was the exception, constipation the rule; in the former condition there was more or less tympanites when gurgling in the right iliac fossa occurred on pressure; in the latter condition the abdomen was rather flat, and in both it was observed that the flatus and the stools had a marked degree of fetidness.

In severity and duration there was no uniformity. A ratio between the severity of the cases and the quantity of polluted water consumed could usually be made out, but in the fatal case at the cottage, and in another one at a private hotel, there were complications, in a large sense accidental, which had much to do with the termination. Unfortunately, no post-mortem examination was allowed, so that we are denied the final facts of the clinical history, and of the means of confirming or rejecting our theory of the fever.

We may shortly see in print, we hope, from the pen of Dr. Nichols, the physician at Rye, an elaborate and entirely accurate account of the cases of fever which have occurred there, together with the valuable and pertinent observations which he has made on the etiological factors. We can only give the general impressions of an observer having the opportunity of personal contact with the more important and salient facts. The reader will gather that our observations tend to establish the proposition that the fever developed in the new cottage at Rye had its origin in the pollution of the water-supply with decomposing organic matter, and that the type of this fever is different from typhoid. Clinically it presents some analogy to relapsing fever. We believe, however, that it is a distinct form, and may be entitled *septic fever*, if our definition be accepted.

COLLECTIVE INVESTIGATION OF DISEASE.

THE first number of the *Collective Investigation Record*, recently issued by the Committee of the British Medical Association in charge of this subject, enables us to judge more accurately as to the possibility of coördinating the work of individual and scattered members of the profession so as to produce valuable results, and also as to the merits of the particular method to secure this end adopted by the Committee, than was possible at the time of our comment on this subject last month.

It certainly seems that the plan is a good one, and that interesting and useful results have already been obtained. Vague conjectures and guesses as to the connection of a given disease with certain circumstances of the environment, or as to the connection or relative frequency of certain symptoms, derived from a limited field of observation, can be replaced by positive data sufficient in number to permit of the application of statistical methods.

Much praise is due to the Committee for the manner in which they have thus far managed the work, which must have involved an enormous amount of labor. Over 1000 English physicians sent in answers to the question as to observed facts bearing on the communicability of phthisis, the majority it is true being simple negatives, and over 400 reports were sent in on the subject of pneumonia. This is a good commencement, and it is time that the physicians of the United States should begin to aid in the work.

It will be remembered that the coöperation of American physicians was invited by the English Committee in a communication which was presented to the American Medical Association, and was referred to a standing committee, of which Dr. N. S. Davis, of Chicago, is chairman.

In an editorial on the subject in the *Journal of the American Medical Association* for August 25, Dr. Davis suggests that "if each State Medical Society could be engaged in the work of establishing the proper sub-committees in the several districts or counties of its own State, and through a State committee receive the returns from the sub-committees, and after their examination and arrangement, transmit them to the General Committee of the National Organization, it would be more likely to secure results of value, both in regard to quantity and quality, than by any other method." It seems to us that a less complicated method than that suggested is desirable, at least for a commencement. There certainly seems to be no necessity for having the returns sent back through sub-committees and State committees for examination and arrangement. Why should not each observer send his return directly to the Chairman of the General Committee?

Moreover, the Chairman of the General Committee ought to be able to select at once from the members of the Association at least half a dozen physicians in each State, and call on them to make a commencement, using at first the sets of questions prepared by the English Committee. When these gentlemen have become familiar with the work by actual trial, they will be the proper persons to bring the matter before State and local societies, and secure a larger body of observers.

No doubt we shall have questions of our own presently, enough and to spare, but at first it seems

to us that the wisest thing that can be done is to obtain answers to the English queries, and to forward these answers to the English Committee for collation and comparison with the data which they collect in their own country. The results will appear in their record, which will thus become an international one. There need be no fear of loss of individuality, and very soon we can in turn call for aid from across the Atlantic in the solution of some of our own special problems. The best way to make a beginning is to begin, and to secure this, individual, direct effort is worth any number of committees.

In the editorial above referred to, Dr. Davis gives the English memorandum on pneumonia and the schedule of information desired for each patient suffering from this disease. Are there not among the members of the Association, all of whom receive the Journal, two hundred physicians willing to commence at once to make observations, and forward reports, if asked to do so by the General Committee? We certainly think there are, and that the sooner such a request is made the better. No doubt some of the returns forwarded at first will not be complete, or specially valuable, but even these will have an educational value to those who make them, and in this way the real workers will become manifest. It is to be hoped that the experiment will, at all events, be tried without waiting for the action of State societies; in fact, as suggested above, it will be an excellent means of securing action on the part of such societies, the importance of whose coöperation we by no means undervalue.

EXTIRPATION OF THE THYROID GLAND.

WITH the exception of Billroth, of Vienna, no surgeon has had so large a personal experience with strumectomy, thyroidectomy, or extirpation of the thyroid gland for benign and malignant tumors as KOCHER, of Berne, who has made a most valuable contribution to the subject in the current number of the *Archiv für klinische Chirurgie*. From having been one of the most fatal, it has, under improved methods of operating, which refer principally to the avoidance of hemorrhage and aseptic measures, gradually become one of the most successful of the major surgical procedures, especially when the gland is the seat of the innocent neoplasms. The truth of this statement is shown by the statistics which Kocher has collected from various sources, the majority of the cases having, however, been met with in Switzerland. Thus of 70 operations performed prior to 1850, 41 per cent. proved fatal, while of 146 practised previous to 1877, only 21.2 per cent. were lethal. Since 1877, 268 cases show a mortality of only 44, or 16.4 per cent., the rate of deaths for the malignant having far exceeded that for the benign growths. Of 28 examples of the former, 16, or 57.1 per cent., perished, while of 240 instances of the latter, 28, or 11.6 per cent., were fatal. It is, moreover, of great practical interest to note that, of the 268 cases, the entire gland was removed in 115, with a mortality of 12.1 per cent., which is not greater than that after partial extirpation.

The individual experience of Kocher relates to 101 cases, of which 13, or 12.8 per cent., died, a most excellent result, when the magnitude and dangers of the procedure are taken into consideration. Of his last 43 operations, which were performed with antiseptic precautions, all save 3, or 6.9 per cent., survived. Of these, 4 were for malignant growths, and 39 were for innocent tumors. Of the former, 1, or 25 per cent., was fatal, while of the latter, 2, or 5.1 per cent., perished. This small mortality forms a striking contrast with the experience of Julliard, of Geneva, recorded in the *Revue de Chirurgie* for August of the present year. Of 31 operations performed by that surgeon for benign formations, 5, or 16.1 per cent., proved fatal. Of 8 partial extirpations, all recovered, while of 23 total excisions, 2 died upon the table, and 3 succumbed subsequently.

In a voluminous and exhaustive paper, contributed to the *Bulletin de l' Acad. Roy. de Med. de Belgique*, for 1883, Liebrecht, of Lüttich, has analyzed 322 cases of strumectomy, with the result of confirming the conclusions of Kocher. He shows that total extirpation is not more fatal than the removal of portions of the gland, and that the mortality has progressively decreased, under more careful management, until it has reached 14.81 per cent. for the past six years.

THE AMERICAN GYNECOLOGICAL SOCIETY.

THE eighth annual meeting of this Society in Philadelphia, the proceedings of which we give in another column, calls forcibly to mind the remarkable progress of this specialty in the comparatively short time it has existed. It is quite within the memory of the younger members of the profession when gynecology was little more than a name, scoffed at by the teachers of "Obstetrics and Diseases of Women," and regarded with some curiosity by others in the profession, whose field of labor this new department did not invade. But in a very few years the obstetricians have seen this new birth grow into a most vigorous and brilliant adolescence. In so short a time the representatives of the specialty of gynecology have contributed not only to the saving of life and health in their own domain by ways heretofore unthought of, or deemed impracticable, but also to the solution of some of the gravest

questions in the practice and philosophy of general surgery.

Gynecology now stands before the world as a well-defined and, it must be admitted, a well-regulated specialty. It contains within itself the elements of safe guidance; for among the number of its most devoted and most eminent followers are to be found those who constantly warn their less discreet fellows of the impropriety and danger of zeal without knowledge.

In the meeting just held, for example, several of the most distinguished speakers condemned the practice of too readily making vaginal examinations of young unmarried women, which not only is—as it was there characterized—a sin, but also has brought reproach on the specialty. The duty of refraining from operation when not clearly demanded was also dwelt upon. Thus it is seen that the principles of true conservatism did not lack able support in this meeting, and a large amount of attention was there bestowed upon subjects which make no appeal to a love of glory. The discussions were full and intelligent. The various subjects, almost without exception, elicited the opinion of those best fitted to speak concerning them, and the papers and discussions together constitute an important and valuable addition to the literature, not only of gynecology, but also of the science of medicine, of which it is just now so conspicuous a part.

SEVERAL of the New Jersey seaside resorts are busy on the subject of water-supply. Long Branch finds its supply insufficient to the extent it has endeavored to furnish. Atlantic City has now a full and abundant supply.

Ocean Grove has just completed a driven well which furnishes an abundant supply of good water. An analysis has been made by Prof. F. A. Wilbur, of New Brunswick, which shows it free of all organic matter. The mineral matter gives but 8 grains of solids to one gallon of water. The success of this well will probably lead to the driving of several others in different parts of the town, which will be controlled by the Association, and will furnish an abundant supply for all.

THE issues of the *Melbourne Argus*, between May 26th and June 21st, are teeming with correspondence in relation to the case of one Rev. Mr. Danne, who, after serving, as is alleged, as a dresser or clinical clerk in a hospital for twelve months, and having attended certain courses of lectures in an irregular and unsystematic manner, came to America, and at the end of nine months returned a full-fledged M.D., with a diploma from the Medico-Chirurgical College of Philadelphia.

We ascertain that Mr. Danne did graduate from the Medico-Chirurgical College in March last, but we can hardly think it possible that he was graduated with a knowledge by the Faculty of the limited preparation charged in the Australian journals. It is more likely that he claimed *ad eundem* qualifications which were unwittingly received by the Faculty. Too much vigilance cannot be exercised by our medical schools in admitting to advanced standing, and only the most conclusive evidence should be received as to instruction claimed to have been received elsewhere. The standard claimed by the Medico-Chirurgical College is a high one, and if adhered to, in view of existing competition, reflects great credit upon it.

The affair is to be regretted, because it furnishes foreign journals a chance to give another fling at the American medical diploma, which is already low enough in estimation abroad, where no discrimination is made as to its source, almost all schools sharing alike in the general opprobrium.

Since it is impossible to elevate the general reputation of the American diploma, in the face of the constant indifference of certain schools at home, it is important that those colleges which do affect a high standard should live up to them.

SOCIETY PROCEEDINGS.

AMERICAN GYNECOLOGICAL SOCIETY.

Eighth Annual Meeting, held in Philadelphia, September 18, 19, and 20, 1883.

(Specially reported for THE MEDICAL NEWS.)

FIRST DAY, TUESDAY, SEPTEMBER 18TH.

MORNING SESSION.

THE Society met in the Hall of the College of Physicians, and was called to order at ten A.M., the PRESIDENT, DR. GILMAN KIMBALL, of Lowell, Mass., in the Chair.

DR. DUER, of Philadelphia, made a short address of welcome.

On motion, the following gentlemen were invited to attend the sessions as guests of the Society:

Dr. Alfred Stillé, President of the College of Physicians of Philadelphia; Dr. W. M. Welch, President of the Philadelphia County Medical Society; Dr. R. A. Cleeman, President of the Obstetrical Society of Philadelphia; Dr. James Tyson, President of the Pathological Society of Philadelphia; Dr. R. P. Harris, of Philadelphia; Dr. J. R. Page, of Baltimore; and Dr. Robert Wilson, of Baltimore.

DR. JOSEPH TABER JOHNSON, of Washington, D. C., then read a paper on

SUPERINVOLUTION OF THE UTERUS.

In this he said he wished to call attention to a disease of the uterus which Sir James Simpson named and described over thirty years ago; but in regard to the settlement of the true etiology and treatment of which so little progress has been made, that he introduced the subject here with the hope that a discussion might follow which would throw light upon it.

Though scarcely referred to by the text-books, Barnes believes this condition to be far from uncommon.

Frommel found it present in twenty-eight out of three thousand gynecological cases, that is, in almost one per cent. of all cases treated.

Superinvolution should be distinguished from atresia of the uterus, undeveloped uterus, or one whose cavity has become obliterated by inflammatory process not involving the diminution of the organ. As the name implies, superinvolution occurs only after the process of involution has been set up after the emptying of a uterus once occupied by some body which has produced an increase in its size, as, for instance, after hydrometra, physometra, hydatids, the removal of uterine tumors, as well as upon the conclusion of utero-gestation, or abortion. The process may be carried from the slightest shortening to the complete disappearance and obliteration of the entire uterus and ovaries.

As a clinical contribution to the subject, he related points in the history of four cases in his practice.

The first case, aged 26, began to menstruate at 14, and continued without interruption until her pregnancy, five years ago. She was delivered with the forceps. The child was still-born. The mother did well until the third day, when symptoms of septicæmia developed. A laceration of the cervix and perineum was found, but no metritis. She made a good, though somewhat slow, recovery from the septicæmia. Later on, she had a continuous leucorrhœa, offensive at the time of her menstrual periods, backache, and distressing sick headache, culminating in absolute prostration on the day when the menses should have appeared. After two years her abdomen enlarged, and she believed herself pregnant, but at about the date of her supposed accouchement she began to lessen in size, and soon regained her usual figure. During this spurious pregnancy there had been a notable general increase of flesh, which remains to the present day. She had not menstruated since the date of her actual conception. Being asked to see her on account of this fact, two years ago, the only explanation of her persistent amenorrhœa found was a uterus measuring less than two inches in depth, hard, fibrous, and movable in all directions upon the point of the sound. Manipulation caused not the slightest pain. The shortness of the uterus being attributed to a distinct bilateral laceration of the cervix, he supposed that its restoration might perhaps cause a reappearance of the catamenia. The edges of the laceration had never healed. She had lost all sexual desire, intercourse was distasteful, and was at times followed by a slight flow of bloody mucus.

The operation proved successful only so far as to relieve the existing lesion, to cure the offensive leucorrhœa, and backache, and to restore the sexual appetite. The sick headaches became less severe than formerly, but did not quite disappear. The uterus remains hard and firm, and still measures less than two inches. The menses have not returned, and she is now only twenty-six years of age. She was subsequently treated with minute doses of ergot, nux vomica, galvanism inside and outside of the uterus, over the ovaries and sacral region, small blisters and massage, but nothing has been accomplished toward the development of the uterus or rousing it into functional activity. The patient now presents the appearance of the most robust health, though entirely without a sign of returning catamenial discharge.

The second case, aged 30, was in the best of health until nine years ago, when she had brain fever, followed by slow convalescence. Soon after getting up she had typhoid fever, and has since found it necessary to live free from mental or nervous excitement. Several years ago, she had a miscarriage, from which she made a good recovery, no fever or inflammation following. Four years ago, her uterus enlarged during eight months, but finally discharged a great quantity of water, since which time she had seen but little of her sickness. This began with uterine pain, backache, and headache, and continued less than two days; the discharge was red at first, soon became pale, and shortly ended with scarcely a stain. In December, 1882, her periods were about half a day and were growing less. The sexual instinct was strong. Her uterus measured less than two inches, and was hard, firm, and painless upon manipulation. She was treated with galvanism, minute doses of ergot, strychnia, counter-irritation, and massage, for three months, with excellent results, so far as the development of the ovarian and uterine functions were concerned. She menstruated seven days at her last period. Her husband tested her capacity for impregnation on the last day of her menses. She missed her next period, and during the next two months experienced many of the usual gastric and nervous disturbances of pregnancy. When she left the city, she was believed to be about two months advanced in utero-gestation; but her anticipations were never realized. The symptoms of pregnancy continued but a short time; the periods came on again, profuse at first, but gradually diminishing in quantity, until she had scarcely any, and showed no benefit whatever from her treatment.

The third case menstruated at 17. Her periods were always painful, irregular, and, as a rule, scanty, though several times they were quite profuse. She had been married three years when she presented herself for treatment, and was twenty-nine years old. Like the other two women, she was very anxious to become a mother. Upon examination, her uterus admitted the sound not quite two inches. She had never been pregnant, and therefore her case might hardly be called one of superinvolution, but it resembled the others so closely in the dimensions of the uterus, symptoms, and indications for treatment, that it was included in the paper with this qualifying statement. The uterus was freely movable. The roughest manipulation caused no pain nor hemorrhage. An electrode was passed through the internal os, while the opposite pole was held alternately over the uterus and ovaries, and occasionally over the sacrum for half an hour, three times a week. Her general health being good, no medicine was given. In the course of the second month of treatment, the organ gained somewhat in capacity, and the menstrual flow slightly increased. She suspended treatment July 1st, and went into the country for the summer, expecting to return and resume in October; but her periods have since shown so little change that she is discouraged, and thinks that it is of no use to persist. Had she remained longer under treatment, she might, perhaps, have been permanently benefited.

The fourth case had had two children. They were both dead, and she was anxious for another. She was only twenty-seven years of age, but thought her change of life had occurred, as her periods lasted now but a few hours, and after the first show the discharge became quite thin and pale. Her uterus measured but one inch and three-quarters. It was hard, very movable, and, like the others, painless upon manipulation. She was treated about like the others, but failed entirely to get any permanent good.

These experiences are far from encouraging, but the results are no worse than usually occurs in the experience of others. Sir James Simpson, who first called the attention of the profession to the symptoms, prognosis, and treatment of superinvolution of the uterus, in an article published in the *Edinburgh Monthly Journal of Medical Sciences*, in August, 1852, met with no better success.

The literature of this subject is not extensive, many of the text-books upon diseases of women not even

mentioning its existence. The points upon which all writers agree, who devote any space to its consideration, are, that excessive involution of the uterus does, from some unknown cause, take place; that galvanism and electricity should be faithfully tried, but that the great majority of cases are incurable. Sinclair, of Boston, read a paper on superinvolution before the Boston Obstetrical Society in November, 1876, in which he explained the production of superinvolution as due to a lack of force in the nutrition with consequent enervation, whereby the fatty degeneration of the uterine fibres was carried beyond the normal point of arrest, with a failure in the renewal of the muscular fibres from their nuclei. Barnes says, superinvolution is produced when the disintegrating process set up after delivery goes on to such an excessive degree as to reduce the uterus to a size decidedly below its normal dimensions in the unimpregnated state. Dr. Walter Whitehead relates a case in the *British Medical Journal* for October, 1872, in which the uterus and ovaries completely disappeared after labor. Courty and Scanzoni mention these atrophied uteri following labor and abortion, and adopt Simpson's name. Hart and Barbour say frankly that the cause of this condition is unknown. Frommel attributed most instances to protracted lactation. This could not have been the cause in two of the author's cases, as in one the child was still-born, and the other followed a miscarriage. Inflammation causing a destruction of the ovary by atrophy, or by compression by the products of inflammation, may result in atrophy of the uterus. Klob has seen cases associated with the tuberculous diathesis. Edis says that cases not unfrequently occur where the mere effort of reproduction has been too much. Superinvolution of the uterus occurs and amenorrhœa follows. As a natural consequence there is a cessation of all further functional activity of the generative organs. When this condition occurs there is little or no hope of accomplishing restoration by any known form of treatment; but judging from the first and fourth cases of the author, where the physical organization remained so perfect it would seem that something might yet be done to enable these patients to bear children.

DR. FORDYCE BARKER said that this trouble was likely to occur, not only in conception, but also after any abnormal development of the uterus; after fibroids, for example, the same process taking place as after labor. So after some cases of uterine catarrh. In all these conditions the uterus is increased, and afterwards there follows a state of retrogression. In all, the trouble depends upon the fact that this process passes its normal point. In regard to frequency, the experience of each one would be influenced by the fact that he was engaged in private practice, or had a large consultation practice. The latter would naturally see more cases than the former. He wished also to refer to a practical point, not mentioned by others, not even by the author of the paper; he had never formulated it himself before, although he had spoken of it to his friends. The point was in regard to the treatment—where treatment could be undertaken hopefully and where not. This depended upon whether there was an associated diseased condition of the ovaries. If the superinvolution was associated with arrest or deficiency of ovulation, very little could be effected by treatment; but when associated with active ovaries, it can be treated, and, he believed, much good could be done. He then gave the signs indicating activity of ovulation, and illustrated his point by a case in which, after an accident to a lady six months pregnant, miscarriage occurred, after which her menses were never normal, though she had the indications of functional activity of the ovaries, and was a great sufferer at her menstrual periods. He dilated her cervix before each period, and treated her with iron and other tonics during the intervals. The result was that she became pregnant again, and has had another child. He also narrated two other cases of the same sort.

DR. A. REEVES JACKSON expressed his surprise at the evidence of comparative frequency of this condition, as indicated by the author of the paper. He had seen but a single case, and that was of doubtful diagnosis. A patient of his after labor had defective lactation; her menstrual flow did not reappear; her mammary glands shrivelled; her skin wrinkled, and she had all the appearance of premature old age. Her cervix was button-like and small. No os was discernible. The body was felt with great difficulty, and was very small. The ovaries were not detectable at all. A sound could not be passed into the depression in the cervix which he took to be the os. Finally he took a probe, and pressed it in, and it passed on and on until he was alarmed, and concluded that he had punctured the fundus. This, however, did no harm. He tried the use of a galvanic stem pessary, but this did no good. He questioned whether this was a case of premature climacteric, or one of superinvolution. He considered the point in regard to treatment made by Dr. Barker to be of great importance.

DR. VAN DE WARKER, of Syracuse, called attention to a possible source of error, depending upon the atrophy of the posterior lip of the cervix, so common in lacerations. This would make the uterus seem to measure much less than normal.

DR. H. P. C. WILSON, of Baltimore, said that while he has seen many cases of undersized uteri in unmarried women and those who have not borne children, he has seen only two or three cases in those who have been pregnant. He considers this a very rare occurrence, much more rare than would be supposed from the paper just read. Dr. Barker, he thought, got at the kernel of the matter in deciding as to the prospect of recovery, and his experience would bear out that of Dr. Barker.

DR. ROBERT BATTEY, of Georgia, spoke of this condition as one of the results of the operation known by his name. The removal of the ovaries is the cause of atrophy of the uterus. The question is one of the ovaries and not of the uterus. The condition of the uterus depends upon want of proper ovulation. He does not agree with Lawson Tait in depressing the influence of the ovaries. The latter regards them of comparatively little importance. The best treatment consists in the use of electricity applied so as to influence the ovaries rather than the uterus. At the same time, the cavity of the uterus may be dilated with tents or by some other means.

DR. BYFORD, of Chicago, said that the subject was one not yet exhausted. There still was a great deal of confusion in connection with it, and little actual knowledge. The process was not well understood, but a distinction should be made between superinvolution and atrophy. The question is, whether superinvolution is one of the stages toward atrophy or not. So long as the uterus retains its characteristic fibres, there is a chance of its recovery. He would divide the subject into simple and complicated superinvolution. In the former, the uterus alone is affected; in the latter, both the uterus and the ovaries. After labor there is a change in the whole of the pelvic contents, the ovaries as well as the uterus. But sometimes the involution of the uterus is greater than that of the ovaries. The condition of the ovaries naturally affects the question of the cure, since the uterus shares the processes of the ovaries. He agreed with Dr. Barker as to the indications for treatment. He would use before the periods, uterine pessaries to cause local congestion, which the ovaries would keep up.

DR. H. F. CAMPBELL, of Georgia, did not think it necessary that the ovaries should be involved or that there should be atresia. He cited a case where sterility followed great distention of the uterus by dropsy of the amnion, though ovulation continues.

DR. JOHNSON closed the discussion. He expressed pleasure at the point made by Dr. Barker, in regard to treatment. He also thought that superinvolution of the ovaries might be a cause of superinvolution of the womb, but did not think it could be regarded as the only cause; and when the activity of the ovaries continues, treatment of the uterus is likely to be successful. Where the ovaries are involved, all treatment is ineffective. In regard to the point made by Dr. Van de Warker, he would say that, in a case where the latter supposed there might have been laceration of the cervix, he had taken note of this point, and it might be remembered that he had operated and cured the laceration, but the superinvolution was not benefited.

The next paper was by DR. R. STANSBURY SUTTON, of Pittsburg, Penn., and was on the

IMPORTANCE OF CLEANLINESS IN SURGICAL OPERATIONS.

He said that, having been out of the country for some time, he would endeavor to bring before the members of the Society something which had been suggested by his observations while absent. He reminded his hearers that the era of open treatment, in which wounds were encouraged to suppurate and granulate, had been brought to an end by the treatment of quacks, who closed wounds up with a variety of substances. Formerly, the belief had been that all bad influences upon wounds came from within. In the present era the current theory is that all bad comes from without. The cell theory was soon followed by the germ theory. Organisms were found in wounds, which were believed to set up noxious processes.

Mr. Lister has endeavored to meet these dangers by carbolic acid and cleanliness. The consequence was greatly improved results. These were attributed at first to the carbolic acid, but it was afterwards ascertained that the amount of carbolic acid used was not enough to destroy the micrococci. A war of arguments and statistics followed, the outcome of which has been to prove that, under Listerism, surgery has achieved better results than ever before. But much of the misunderstanding has depended upon the assumption that Listerism is carbolic acid, and carbolic acid is Listerism. It has been shown by the experience of Keith, Bantock, and Tait that equally good results can be secured without the use of Listerism, yet it is premature to condemn the theory. There may yet be found another antiseptic, which will give better results than carbolic acid. It has been clearly shown that all bacteria are not malign. Bacteria swarm at the orifices of the body, yet we do not hear that the dental surgeons are troubled about them; and Mr. Allingham, in his operations upon the rectum, has had almost invariably good results, under what might be supposed to be the most disadvantageous circumstances. Nor is the danger uncommonly great in vaginal operations, yet some precaution should always be taken against noxious influences. Special cleanliness should always be observed in surgical operations. Since this was impressed upon the surgical world by Mr. Lister's methods, septic disorders have greatly diminished. For the attainment of the greatest cleanliness, time, knowledge, and constant practice are demanded, and Lister has taught us this, if anything. Carbolic acid, it should be said, is not to be denounced because of occasional unfavorable consequences, unless it can be shown that it does more harm than it does good. Very often the different results attained by those who practise Listerism and those who are opposed to it can be attributed to the difference of ability to attain cleanliness of person and instruments, and assistants and nurses, on the part of different surgeons. Keith has become such an expert in cleanliness that for him the spray was a disadvantage. In a three months' visit which he had made to Keith, all of the cases of the latter in which he had used the spray, occurring in the public hospital, died; and no case occurring in Keith's private hospital, treated without the spray, died. The Germans have received very great advantage from the use of Lister's method, for this has taught them the highest degree of cleanliness. German surgery is supposed to have formerly been extremely dirty, Now it is absolutely clean. If, after this lesson has been learned, the spray be dropped, the comparative effect of spray and cleanliness can be ascertained, because of the lesson of cleanliness taught by Listerism. He would recommend all surgeons to practise the antiseptic method until this lesson was thoroughly learned; then they may modify the system as experience may dictate.

DR. BARKER moved that the Nestor of American Surgery, Dr. S. D. Gross, who was present in the room, be asked to open the discussion. The motion was carried.

DR. GROSS thanked the Society for the compliment, but said he came to listen, and not to talk.

DR. EMMET, being called upon by the Chair, said he had nothing to add. He would simply observe that he agreed perfectly with the remarks of the author of the paper. As he had elsewhere stated, he believed in cleanliness, and that the surgeon often carried the death-warrant of a patient under his finger-nails. He trusted to soap and water more than to any disinfectant. He spoke of the difficulty of controlling one's assistants, and stated that Tait does his own sponging, and does not allow his assistants to touch any instrument or dressing if possible.

DR. W. T. LUSK, of New York, said that some things in the description of Listerism in the paper just read, would suit the most ardent Listerite. He agreed with the main point of the paper, but he objected to the inference which he thought might be drawn from it, that the spray was not only useless, but also harmful. Lister thinks there are certain influences adverse to healing, which are not appreciable by the senses, and he trusted to the spray to do away with these. Though micrococci resist five per cent. solutions of carbolic acid, yet this strength is fatal to the germs which produce putrefaction, and it is in the presence of putrefaction that the micrococci are dangerous. For himself, he felt that he could not give up entirely the use of the spray, although he knew the importance of the other points urged, since he had seen it effect such changes in the results of surgical operations in the hospital with which he was connected. In regard to the statement, that during Dr. Sutton's visit to Keith all cases treated with carbolic acid died, while all treated without it recovered, he must express his opinion that it was not attributable altogether to the carbolic acid; for, in 1878, when he saw Mr. Keith, the latter showed him the records of his operations, exhibiting a large number of consecutive recoveries under the spray, and told him that the English surgeons would have to come to the use of carbolic acid. At that time he was using the method of Lister, and yet his results were extremely favorable. Thornton, who still uses Lister's method, gets admirable results. Mr. Tait is the strongest believer in simple cleanliness, and scoffs at many points in Listerism, but he had the impression that Mr. Tait's success was largely due to exceptional address and skill on the part of the operator. For many of his abdominal operations he made a very small incision and operated with the greatest rapidity.

Still, while Keith, Bantock, and Tait may be allowed to do as they please, he thought that for many of us Listerism is a very good thing, and that it enabled even tyros to enter the ranks of the great coryphæi of surgery.

DR. WILSON, of Baltimore, referred to the obligation all surgeons are under to Lister. All practise, more or less, the method of Lister, although many of them abandon the spray. It has brought about such changes in the operation of ovariotomy, that not long ago Mr. Keith said that he thought no woman should die from the operation if she came to be operated on soon enough.

DR. CAMPBELL, of Augusta, Georgia, spoke in defence of the cleanliness of old operators, and repudiated the idea that they had learned cleanliness from Mr. Lister.

DR. SUTTON, in closing the discussion, said, in allusion to the statement that Mr. Tait used carbolic acid on his sponges, that he carefully washes all the carbolic acid out of them before using them in his operations. He thought that the day of the spray had gone by, and that if it ever did any good, it was by wetting the floor, and entangling the germs, so that they could not rise. Some of the most successful British operators were scrupulous in regard to their assistants. Mr. Keith had only one; Mr. Tait only one. On the contrary, Dr. Billroth had very many, and his methods were very different from those of Tait. He had remarkably good results, although he operated upon the most desperate cases, refusing no one who had any chance of life. He had no faith in statistics, in regard to laparotomy—so much depends upon the individual operator, and upon the different kind of cases which each may happen to have.

AFTERNOON SESSION.

On motion, Doctors R. P. Maury, of Memphis; Wm. E. Mosely, of Baltimore; W. P. Chunn, of Baltimore; and S. D. Gross, of Philadelphia, were invited to participate in the proceedings.

DR. ALBERT H. SMITH, of Philadelphia, then read a paper entitled

HOT WATER IN SECONDARY HEMORRHAGE AFTER PELVIC OPERATIONS.

The use of hot water, he said, had been first suggested in 1859 by Dr. Emmet. He himself had later begun the cautious employment of it to control hemorrhage after labor, and then adopted it regularly for the treatment of post-partum hemorrhage, and had come to regard it as the only needful treatment. He now uses it as a prophylactic, heated to a temperature of 115° to 120°, disinfected, and injected into the vagina in all cases of labor. He continues the injection until the water comes away clear of all tinge. He finds it grateful to the patients, and satisfactory to himself. In regard to operations, he spoke of the confusion and difficulty caused by hemorrhage. Here the hot water was not only harmless, but absolutely beneficial. In secondary hemorrhage, we have in the hot-water douche a remarkable aid.

He referred to some operations of Dr. Skene, in which the results had been very adversely influenced by hemorrhage, which influence might have been successfully controlled, and the results made successful, had Dr. Skene been familiar with the use of hot water as a hæmostatic. He narrated a very striking case of his own in which secondary hemorrhage occurred after a very difficult operation for the restoration of a badly lacerated perineum, and recommended the use of the hot-water douche on account of its simplicity and efficacy.

DR. REAMY, of Cincinnati, said that he had been for some time in the habit of using a stream of hot water on the perineum, instead of sponges, in every operation. He has also used hot water in secondary hemorrhage.

DR. CHADWICK, of Boston, being called upon by the Chair, endorsed the remarks of Dr. Smith.

DR. WILSON, of Baltimore, spoke of the method recommended by Dr. Smith as invaluable. It was apt to be overlooked because it was simple, but there was nothing so good in post-partum hemorrhage. He cited the case of a friend of his who encountered profuse hemorrhage after a Battey's operation. The hemorrhage came through the opening in the cul-de-sac of Douglas. At his suggestion, the nozzle of a syringe was passed into the peritoneal cavity, and hot water injected until it came away perfectly clear. The patient recovered. He thinks she would have died, except for this expedient.

DR. H. F. CAMPBELL spoke of the use of the tincture of iodine, one part to three of water, in post-partum hemorrhage, which he has found very satisfactory.

DR. MANN, of Buffalo, said that all the remarks thus far made had been favorable to the method, and he was sorry to have to say that his experience had not coincided entirely with that of Dr. Smith. About a year ago, he had used the hot water in an operation for cancer of the cervix which terminated fatally. He had removed the new growth with scissors all the way up to the internal os. He then injected vinegar until the whole cervix was perfectly clear and white. Seeing a small piece which he thought should be removed, he raised it and snipped it off; instantly the vagina was filled with blood. He injected vinegar, but it did no good; he then injected hot water, and the hemorrhage, if anything, was greater than before. He then tamponed; this, too, failed. He then used the Paquelin cautery, which checked the hemorrhage a little. He then tamponed with the persulphate of iron, but the patient became pulseless, jactitation came on, and in ten minutes the patient was dead. Dr. Mundé had a case of secondary hemorrhage, with the same result. The method was not infallible, and could not be relied on in every case.

DR. GOODELL, of Philadelphia, said that Dr. Mann asked too much of the hot water in his case. He had found the hot water particularly good for some cases, namely, those where there was oozing. It sometimes fails. It is not fair to compare hot water and vinegar. Hot water does good beyond the surface which it reaches, while vinegar only does good where it comes into contact. This he had found in cases of menorrhagia, where the use of hot water is successful, although it does not come in contact with the bleeding surface. In most operations he prefers vinegar, but for hemorrhage in general he thinks the best hæmostatic is hot vinegar, because with this we have the advantages of vinegar together with those of heat. At the Preston Retreat he uses constantly a mixture of vinegar and hot water after labor.

DR. FORDYCE BARKER, of New York, called attention to the necessity which sometimes occurs for great haste in checking hemorrhage. Sometimes one cannot wait. He cited a case, occurring last winter, where a newly married couple, arrived at New York, and on the first night the bride had a violent hemorrhage. A physician who was called in tamponed the vagina, and, this failing, packed it very thoroughly a second time. In a few minutes, however, the hemorrhage reappeared. He now cleared out all the clots, applied Monsel's solution, and filled up the vagina with cotton. In a few minutes oozing reappeared and he made a second application of the same kind. After this, he sent for Dr. Barker, who used the hot-water douche, but it acted very slowly, and the woman nearly lost her life from hemorrhage. He sometimes questioned whether

the force of the hot water did not do harm. In a second case, somewhat similar to the one just mentioned, he had checked the hemorrhage by very gently applying cotton dipped in ergot. His objection to the hot water was that it took too long to act.

DR. BYFORD, of Chicago, being called upon from the Chair, expressed his concurrence in Dr. Smith's views.

DR. SMITH, in closing the discussion, expressed gratification at the almost unanimous testimony in favor of hot water. In regard to Dr. Mann's case, he said that he had seen similar ones where the hemorrhage was completely controlled by the hot water. In such cases, when hemorrhage is profuse, one must get some slowing of the blood-current by elevating the hips, so that when the hot water comes in contact with the bleeding surface it shall be able to produce its full effect. Dr. Goodell, he thought, was really using hot water, when he spoke of the use of hot water and vinegar. This was simply water medicated with vinegar. In Dr. Barker's case, where the persulphate of iron had been used, he thought much of the difficulty may have been attributable to the action of the iron in preventing the possibility of the usual action of hot water. He, himself, had seen cases of post-partum hemorrhage where the uterus was firmly contracted, and yet a stream of blood the size of a goose-quill was issuing from it, where the application of hot water had stopped it promptly and effectually.

DR. GOODELL rose to explain that what he spoke of as hot vinegar was not simply medicated hot water, as Dr. Smith supposed, but vinegar heated by the addition of hot water.

DR. C. D. PALMER, of Cincinnati, then read a paper on

SOME POINTS CONNECTED WITH THE SUBJECT OF DYSMENORRHŒA.

He spoke of the importance of the subject, its effects, direct and remote, and referred to the diverse opinions which are even to-day entertained concerning its true pathology and appropriate treatment. A short history of the mechanical theory, as advanced by Macintosh, Simpson, Sims, Barnes, and others, was given, the acceptance of which was most natural, because of its directness, simplicity, and plausibility.

In the light of modern gynecology, and with the present facility for thoroughness of pelvic exploration, no one can doubt that obstructions in the uterine canal do exist, and that these may serve to create pain in menstruation. They may arise from abnormities of the cervix, stenoses, congenital or acquired. These stenoses are by far more common at the external os than at the internal. Organic stenoses at the internal os, except from flexion, are quite uncommon. Obstructions may arise along the uterine canal from flexions and fibroids. Membranous dysmenorrhœa is a clear sample of impeded menstrual flux. Objections were made to much of the mechanical doctrine for the following reasons: A want of uniformity between the seeming causative lesions or abnormities, and the manifestation of symptoms. This want of uniformity is noticeable in the seat, degree, kind, duration, and time of the occurrence of pain.

When real obstructions do exist, the most severe attacks of pain are rarely present. A patient may writhe in the agonies of the most severe menstrual pain, when a medium-sized sound can easily be passed. Nor are labor-like pains characteristic of obstruction. Pain may reach its climax with the uterine cavity empty, and while not a single drop of blood escapes on the introduction of a bougie.

In reference to flexions, the pain is not in proportion to the degree of flexion, and straightening of the uterus by no means always cures it. A considerable proportion of cases of flexion are unattended by any menstrual pain, at least till some other disease is superadded.

The following varieties of cases have doubtless been witnessed by every gynecologist, and illustrate the want of uniformity referred to.

1. Instances of dysmenorrhœa, when no abnormal condition of the uterus, as to size, shape, position, circulation, or in the ovaries, or any pelvic tissues, can be detected on the most thorough exploration.

2. Instances of stenosis of the os externum, of most marked kind and degree, the result of chronic inflammation, or the use of caustics, and no menstrual pain.

3. Instances in which there are well-defined abnormities of the uterus, as in pin-hole os, elongated cervix, constricted canal, flattened and ill-developed body, flexion (ante-), and no dysmenorrhœa.

4. Instances of well-defined acquired flexion of the uterus, and no dysmenorrhœa.

5. Instances of stenosis of the os externum and cervical canal, associated with dysmenorrhœa, where treatment of a surgical nature proves successful in the relief of the former, while temporary or no relief attends the latter.

6. Instances of uteri with patulous canal and dysmenorrhœa.

From the evidence afforded by a study of the clinical history of these cases, we are forced to the conclusion, that not only is dysmenorrhœa not obstructive in all its kinds and cases, but that any impediment to the menstrual flux, as a factor in the production of pain, rarely, indeed, exists. The theory of dysmenorrhœa, based on mechanical obstruction, is not demonstrated.

The nature of the disease is best determined by studying uncomplicated cases, and finally, such as are associated with some organic affection of the uterus.

Reference was made to the extreme sensitiveness of the uterus, at or above the os internum, on the introduction of the ordinary sound in this disease. A slight discharge of blood sometimes follows; but this is not owing to congestion alone, being out of all proportion to it. The sensory nerves of the uterine cavity are in a state of hyperæsthesia or neuralgia. In such a condition, menstrual pain will be excited from the influx and flushing of the tissues with blood. The more dense these tissues, the greater the pain; the explanation of the greater frequency in the unmarried and nulliparæ. And, under such circumstances, local irritants, such as clots of blood, etc., may excite the uterus to painful contractions. But that clots cannot possibly be invariably the underlying cause is apparent by the occasional manifestation of these symptoms for hours prior to the presence of any flow.

Spasmodic action of the uterus as a condition of some dysmenorrhœas is abundantly proven, by the occasional behavior of the organ on the introduction of the sound, the ingestion of irritant fluids, and caustic crayons. Analogous action, we know, is found in the larynx, rectum, and bladder.

Dysmenorrhœa is, then, a functional disorder of the uterus, and, in its essential and underlying nature, a neurosis. It presents many features analogous to other visceral neuralgias, associated or not with organic disease, sometimes developed, but more often aggravated, by them. Clinical evidence points to the idea that the neurotic is the only feature in most cases, and is manifested to a greater or less extent in all.

The temperament of the dysmenorrhœic is generally highly sensitive and impressionable. The local neurosis is an expression of an impaired, disordered, highly developed nervous system. As a want of general development predisposes to this neurotic habit, so do imperfect sexual developments. To repeat: there is, then, such a condition as obstructive dysmenorrhœa.

It is, however, comparatively rare. Many obstructions are seeming and not real. Pain is developed by the local influx to and within an organ the seat of a neurosis, either purely local or a local expression of a general nervous disorder, very generally antedating any organic lesion, and almost always aggravated by such as become acquired.

Concerning treatment, but a few points were touched upon. In all cases of painful menstruation in young, unmarried women, treatment should be purely constitutional, at least for a time, until the necessity for a local exploration is clearly and justifiably apparent. If there is a sin in the profession, it is the unnecessarily frequent and unwarranted liberty assumed on the part of many practitioners, women as well as men, that, because a young female suffers pain at the menstrual period, she must have some local uterine disease, and is a fit subject for local treatment. In thousands of instances all over the country is this injustice being done young women, an injury which must reflect itself back on the profession. At this age and social condition there is, excepting it may be some congenital abnormity, seldom any local disease, or one so trifling and insignificant as to require no local treatment. Local treatment may be needed, fortunately, rarely, and only, after a failure following a general treatment, thoroughly and fairly tested.

During the interval, every attention should be directed towards an improvement of the general health by hygiene, proper diet, dress, and exercise.

Iron and arsenic—each has its indications according to conduct of menstrual flux in quantity, duration, and frequency. Galvanism of the hypogastric plexus and of the spinal centre occasionally accomplishes great good. Failures are also experienced. It is a remedy indicated only in the purely neurotic, spasmodic, or rheumatic forms of the disease.

The author has experienced decided benefit, in some cases, from a prolonged administration of mercuric bichloride and potassic iodide, in small doses, three times a day—results not owing to the relief of any syphilitic complication, or the melting down of any periuterine inflammatory infiltration. The only lesion was a chronic endometritis, and the menstrual pain seemed to be spasmodic.

The author also expressed confidence in the efficacy of the concentrated tincture of cimicifuga and tincture of pulsatilla, given during the attack. He condemned, in strong language, the frequent and uncalled-for administration of opiates, especially morphia hypodermically, which never cure the disease, but which tend to induce a condition of the nervous system more difficult to overcome than the original affection.

Dilatation by sound and bougies did good in stubborn cases, not by securing a larger canal, but by blunting the sensibility of the uterus, and by stretching the irritable fibres of the internal sphincter.

Believing that stenosis is more frequent at the external os than at the internal, it can be understood how, on this ground, sterility is also more frequent and peristent than dysmenorrhœa. It is easier for the menstrual discharge to get out than it is for the spermatic fluid to obtain entrance. Although stenosis may not be a direct factor in the production of dysmenorrhœa, it is, nevertheless, a potent one in creating disease of the uterus—dilatation of the upper cavity, thickening and softening, and granular degeneration of the endometrium, and consequent stubborn catarrh. The uterine walls, likewise, in time, undergo hyperplastic changes. Incision here is preferable to dilatation—an operation which doubtless has been greatly overdone; still, it has stood the test of time. Time has fixed its proper field of utility. With proper restrictions, its dangers are slight and results good. Very little can be added to our knowledge of the *technique* of the operation given us by Simpson, Sims, and Emmet, although Fritsch has proposed some ingenious methods, as applied to the methods of obviating the various forms of stenosis of the external os.

DR. CHADWICK, of Boston, agreed very much with what had been said. For some years he had entirely given up the theory of obstruction, and never used incisions, except those confined to the external os. Some of the causes of dysmenorrhæa, he regarded as purely local, others were constitutional, as, for example, in neurotic cases. These must be treated on a nervous basis. He uses for a week beforehand the bromides, in ten to twenty grain doses, producing some blunting of the sensibilities. During menstruation he used cocoa and carbonate of ammonia, never morphia. He had no faith in dysmenorrhœa being due to flexion, though he knew it might occur as a coincidence.

DR. BARKER, of New York, shared the opinion of the author that obstructive cases constitute but a small proportion of the whole, though they do occur. He thought there were two sorts of pain, one uterine, the other ovarian. For tonic treatment, his preference was for the lactate of iron, which he generally associated with chlorate of potash. He had got very good results from the use of apiol. The way to secure these is to commence its use at least two days before the menstrual period. He gave it in capsules after each meal, and continues it through the menstrual period. In cases where there is ovarian excitement, as manifested by the signs already mentioned, without the relief of a discharge from the uterus, he uses the bromide of sodium in ten to fifteen grain doses. He prefers this to bromide of potash, because he thinks it less likely to cause bromide eruption, which is a matter of great consequence to young ladies. He also arranges the doses so that they shall be taken in the middle of the forenoon, and in the middle of the afternoon, and the last dose just before going to bed, so that the patient does not have the stupefying effects during the day.

WEDNESDAY, SEPTEMBER 19TH, SECOND DAY.

MORNING SESSION.

The meeting was opened by the reading of *The President's Address* by DR. GILMAN KIMBALL, of Lowell, Mass., entitled

A BIOGRAPHICAL SKETCH OF DR. NATHAN SMITH, FOUNDER OF THE DARTMOUTH MEDICAL COLLEGE.

In opening his address he said: Although it has been the custom with those who have filled the position which I now occupy, to devote the hour to the consideration of some subject pertaining to the department of gynecology, I propose to deviate from that rule and devote this, which seems a fitting opportunity of paying a just tribute to one who, by the course of his genius, by his indomitable will and unflagging energy, has done more to advance the practice of medicine and surgery than any other single individual in our country. I refer to Dr. Nathan Smith, the founder of Dartmouth Medical College.

In regard to ovariotomy, he is said to have been the second to perform it successfully, which he did in July, 1821. The operation of Dr. Smith was truly original, and except that McDowell's operation was performed nine years previously, the two operations stand alike. McDowell has been termed the father of ovariotomy, and it is not my purpose to raise any question as to the justice of this claim, but while I do complete justice to McDowell, is there nothing more to be said of Dr. Smith than that he had the courage to follow in the footsteps of McDowell? Dr. Smith performed the operation without any knowledge of the previous

operation of McDowell, and should therefore receive equal credit.

Dr. Smith was born in September, 1762. His early life was spent in Chester, Vermont, where his father followed the occupation of farming. He received what education he could obtain from the district school during the winter. At times he himself taught in the school. He was led to study medicine by witnessing an operation. He desired to begin the study at once, but was advised to first perfect his general education. He began the practice of medicine in the town of Cornish, N. H., when he was thirty-five years of age. At the end of two years, he resumed his medical studies at Harvard College, from which institution he received the degree of M.D. He then returned to Cornish, and continued to practice for six years.

The difficulty of procuring a medical education in New England was so great that he decided to give instruction, and in order to fit himself for this work, he went to Europe to perfect himself. Before starting, he proposed to the authorities of Dartmouth College that they should organize a medical department. His proposition met with favor. He returned in September, 1797, and delivered his first course of lectures during the ensuing fall. In the following August, he was elected Professor of Anatomy, Surgery, Chemistry, and the Theory and Practice of Physic.

In 1812, Yale College decided to establish a medical department, and called upon Dr. Smith to take the position of Professor of the Theory and Practice of Surgery. He began his lectures in this institution in 1813, when fifty-one years of age. In 1816, he was reëlected a professor in the Dartmouth College, but declined to accept, and, in 1817, removed his family to New Haven. In 1821, he went to Boston, and remained there five years. During the last thirty-two years of his life, Dr. Smith gave instruction in about one hundred and thirty-eight special courses. This work began to tell on him, and, while in possession of full mental power, he died on the 28th of August, 1829.

The speaker then referred to the manner in which Dr. Smith had filled the various positions of life, illustrating his remarks by several anecdotes. Dr. Kimball again alluded to Dr. Smith's performance of the operation of ovariotomy, and claimed that Dr. Smith was entitled to the same honors as had been bestowed on McDowell.

DR. S. D. GROSS said that he had thought that Dr. Smith had performed his operation with the knowledge that it had been previously performed by McDowell; his operation having been done thirteen years after that of the latter gentleman, who had operated in 1809. An account of the operation was published in a Philadelphia journal in 1816. Dr. Gross thought that it was very unlikely that Dr. Smith failed to see it. He thought that Dr. Kimball had omitted to refer to the greatest of all Dr. Smith's achievements—he referred to the creation of Dr. Nathan R. Smith, of Baltimore.

DR. KIMBALL.—It will, I think, be in order for me to make a few remarks in reference to the statement of Dr. Gross. It should be remembered that intercourse between the east and west was at this time very difficult. Matters which had occurred in one part might not be known for a long time in the other. In a discussion with Dr. Reuben D. Mussey, who was Dr. Smith's successor in teaching surgery at Dartmouth, I received a detailed account of this operation of Dr. Smith. I fully believe that he knew nothing of McDowell's case.

DR. THADDEUS A. REAMY, of Cincinnati, then read a paper entitled

A RARE FORM OF ABDOMINAL TUMOR.

He described three cases, the first of which was seen by him in July, 1873. The patient was thirty-eight years of age, had been married fifteen years, and was sterile. She had enjoyed good health until three years previously. At this time she discovered an abdominal tumor, just below and to the right of the umbilicus. This tumor had enlarged gradually until it reached the size of the uterus at the eighth month of pregnancy. The woman had always menstruated regularly. She had menstruated two weeks before examination. She appeared well nourished, but there was a little change of the complexion as in the incipiency of the cancerous cachexia. An examination of the patient in the erect position showed the form of the enlargement to be striking. There was bulging in the median line from two inches above the umbilicus nearly to the pubes. The lateral borders could almost be determined by the eye alone. The abdominal wall was comparatively thin. The surface of the tumor was irregular and lobulated. There was fluctuation at every point. At some points the tumor was more tense than at others. This was probably due to difference in the thickness of the cyst-walls. This thickening was especially marked at about the umbilicus. The tumor could be moved a little from side to side, and to a limited extent upwards and downwards. There was intestinal resonance in both iliac fossæ; the bladder was empty. Digital examination per vaginam revealed a normal vagina and cervix. The cervix was slightly anteverted in agreement with a slight retroversion of the uterus. The os was somewhat patulous. The sound gave the measurement of scant three inches. There was no bulging into the vagina. There was no pain or tenderness on pressure.

Supposing it to be of uterine or ovarian origin, Dr. Reamy decided to tap, and he introduced a trocar in the median line, about four inches below the umbilicus. The fluid gushed out with such force as to fall at least two feet from the patient. It had the appearance of blood. The quantity obtained was six quarts.

The fluid was examined microscopically, and was found to contain red and white corpuscles. The size of the abdomen was reduced one-half by the tapping. No inflammatory complication followed. A letter just received states that the enlargement remains about the same.

The second case was seen June 4, 1881. The patient was a widow, fifty-eight years of age, and the mother of five children. Her husband died six years previously of cancer of the stomach. Two years before, an abdominal enlargement was discovered. The patient had noticed it first as a small lump below and to the left of the umbilicus. In two years it had reached the size of the fifth month of gestation. Her general health was good, and the menopause passed. A few days before the family physician was called, she had colicky pains, which were relieved by some domestic remedies. Some tenderness of the abdomen remained. A physician was sent for, the tenderness was relieved, and the case passed from observation until the time when Dr. Reamy was called. The patient was taken sick at midnight, with violent abdominal pain, attended with vomiting of mucus colored with bile. The pain was intense, and continued notwithstanding the free use of anodynes. The abdominal enlargement had increased, since the patient had been last seen, to the size of the uterus at the eighth month. It had remained at this size for one year. The general health had been fair. There was no cachexia. Occasional abdominal pains had been experienced. The patient had a temperature of 103°, and a pulse of 120. The abdomen was very tender. It was clear that the patient was suffering from peritonitis, and it was thought that this might have some connection with the tumor. Opiates were freely administered, and Dr. Reamy was called in consultation the next morning. The temperature was then

100°, and the pulse 130. The woman was delirious. Physical examination revealed marked dulness from above the umbilicus to the pubes, and resonance in each iliac fossa. Fluctuation could be clearly made out. Vaginal examination showed that the vagina and uterus were normal, and that there was no bulging downwards. The diagnosis of general peritonitis was clear enough, but its relation to the tumor was not so clear, although such relation was believed to exist. It was thought possible that the cyst had ruptured, and that part of its contents had entered the peritoneal cavity. It was, however, clear that the amount of escaped fluid could not be great. The tearing of adhesions was thought of, but not seriously considered. The rupture of omental or other bloodvessels was thought of as probable.

As there was such severe peritonitis the performance of any operation was not considered proper. It was decided to increase the amount of opiates, administer stimulants, apply ice poultices, and await further developments. This, Dr. Reamy thought, was a blunder. The abdominal cavity should have been opened. This would have afforded the woman a chance, for, although the tumor proved to be a sarcoma, he could see no reason why it could not have been successfully removed. The patient died soon after.

At the post-mortem, a tumor somewhat pyriform in shape was found. The walls of the cyst were thick at the upper and thin at the lower part. Notwithstanding that the removal of the tumor was done with great care, it gave way, and a portion of its contents escaped into the abdominal cavity. The fluid seemed to be almost entirely blood. There must have been at least two and a half gallons. The tumor appeared to be composed of connective tissue and bloodvessels; there was no connection with the uterus or ovaries. The point of origin must have been the omentum, and, indeed, the greater omentum had entirely disappeared. There were no adhesions to the abdominal walls or organs. Microscopical examination showed that the fluid contained a large number of blood-corpuscles, some of which were normal, but many were broken down. The fluid was colored red by the coloring matter of the blood. There was also a considerable amount of granular detritus. The semi-solid matter which was found presented the appearance of blood-clots.

The third case was seen in November, 1882. The patient was a married woman, fifty-two years of age, and the mother of eleven children, the youngest being ten years old. Menstruation had been regular until three years before, when it stopped suddenly. Five years ago, she noticed enlargement of the abdomen. It was first found below and to the left of the umbilicus. It could be moved slightly from side to side, and was not tender, even on deep pressure. Two years before, she had an attack of pain in the region of the growth, which seemed to have been paroxysmal. This lasted for a day, and was followed by soreness which continued for several days. The tumor then grew more rapidly, and in the next six months reached the size of about an eight month's pregnancy. It then ceased growing and remained stationary until about one week before the patient came under observation. There was then a repetition of the attacks of pain. During the past six months she had lost weight, and her complexion was decidedly sallow. Later she suffered from peritonitis, believed to be due to changes in the tumor. The attack had been ushered in with soreness over the abdomen, and followed by some tympanites.

On examining her, Dr. Reamy found, extending from the umbilicus to the lower portion of the abdomen, a tumor which was spread out like an apron in front of the intestines. The surface of the growth was irregular and lobulated; there was fluctuation; the intestinal resonance was well marked in the iliac fossæ. Examination showed the vagina and cervix to be normal. The sound was not passed.

Impressed with the striking resemblance in history and the results of the physical examination between this case and the two which he had mentioned, he advised tapping, which drew off five quarts of fluid presenting the characters of blood. Microscopical examination of the fluid showed that it had the same characters as that removed from the other cases. After the removal of the fluid, the cyst collapsed, except at a point between the left iliac fossa and the middle line. At this point fulness and fluctuation remained. Thirteen days later, fluctuation having become more marked, he again aspirated, removing sixteen ounces of pus. The patient made a tedious but complete recovery.

He saw this woman last week, and she now looks stout and healthy. She has gained twenty pounds above her ordinary weight.

The foregoing cases seem so much alike that he felt justified in grouping them together. They are sufficiently rare to warrant him in believing that a report of them would not be without interest. He then referred to a number of cases, somewhat resembling those described, which he had found in looking up the literature of the subject.

It is a matter of clinical interest that the first and third cases, which were tapped, recovered, while the second case, which was not tapped, died, and the post-mortem revealed a sarcoma. This raises the question whether these other cases would have become sarcomatous if not tapped, or whether it could be possible that this one had degenerated into a sarcoma. It is possible that these women may yet die of sarcoma.

He then presented the specimens removed from the second patient, and read the report of the post-mortem. The walls of the tumor varied in thickness from that of tissue-paper to a thickness of three inches. The cyst had evidently existed for some time, as some of the following conditions will show. It had formed between the layers of the omentum. The outer lining membrane of the cyst was very thin and friable; closely attached to it were numerous masses of fibres. The wall of the large cyst contained a number of tumors which varied in size from a hickory nut to a hen's egg. Under the microscope these tumors presented different appearances. Around all of the tumors was an evident capsule. There was no broken-down centre in them, though a few hemorrhagic foci were found scattered through them. These tumors were not very vascular, but, wherever a vessel was found, its walls were infiltrated with spindle-cells. Some of them were found to consist of spindle-cells, with large nuclei and very little intercellular substance. Others were smaller and presented a chocolate or brown appearance, and under the microscope resembled cavernous tissue. These were extremely vascular. Here and there were found large hemorrhagic foci. The vessels had been so infiltrated with round and spindle-cells that their tissue had been destroyed. They appeared merely as channels through the growth. In the vascular tumors the round cells predominated.

From the specimen it would appear that it was a cyst which had developed in the omentum; that in the walls of this cyst numerous sarcomatous tumors had developed. One of these tumors had ruptured into the cyst, and there had been recurring hemorrhage which had produced rupture of the main cyst into the peritoneal cavity causing peritonitis from which the patient died.

DR. CHARLES C. LEE, of New York, concurred in the statement that these tumors of the omentum were very rare, and thought that if tapping were more gen-

erally resorted to, our knowledge of them would be advanced.

DR. R. S. SUTTON, of Pittsburg, spoke of the rarity of the tumors and said that he had seen two or three in the practice of foreign operators. He claimed that it was not possible before the abdomen was opened to say whether a tumor was carcinoma or sarcoma of the omentum. It is generally possible to determine that the tumor is in all probability in the omentum, by exclusion, showing that the tumor is not connected with any of the other abdominal organs. If there were fluctuation, whether distinct or indistinct, he considered it a very dangerous practice to plunge a trocar or even an aspirator into the growth. If the surgeon thinks that before he is justified in opening the belly, he must have some of the fluid for microscopical examination, the hypodermic syringe will remove all that is necessary. He also believed that in such cases the surgeon was justified in discarding, not only the aspirator and trocar, but also the hypodermic needle, and making an exploratory opening of the belly. When the abdomen is opened it is possible to determine the location and attachments of the growth and the possibility of its removal; but the exact pathological character of the growth cannot be determined until after removal. If the tumor be sarcoma or carcinoma, there is little hope of prolonging the life of the patient. Sarcoma is as malignant as carcinoma. While carcinoma travels by the absorbents, sarcoma travels through the blood-vessels, so that sarcoma will lead more surely to general infection than will carcinoma. In the latter the liability to return depends upon the character of the sarcoma. The giant-cell variety is by no means so likely to return as the spindle-cell variety. The round-celled and the mixed variety return almost as certainly as the sun after night.

Does sarcoma ever pass into carcinoma, or does a benign growth ever degenerate into sarcoma? In regard to the first proposition, sarcoma never changes into carcinoma. The growth is either one or the other *ab initio*. Of the cases which he had observed, one was in the practice of Hancock, of London. A large carcinoma was removed, but the patient soon died. The remaining two cases were in the practice of Billroth. In one, after the nature of the growth was determined, the abdomen was closed; in the other case the operation was performed. He believed that when the exploratory incision shows that the tumor is malignant, that the abdomen should be closed and the tumor not interfered with.

DR. HENRY F. CAMPBELL, of Georgia, considered the cases of great interest. He thought that it was certainly worth the risk to remove tumors of the omentum if there were no extensive adhesions, and the exploratory incision had been made.

DR. REAMY said: I shall only reply to one or two points. I cannot quite consent to the doctrine which Dr. Sutton advocates, especially in the sweeping way in which he makes it. I understand him to say that it would be more judicious to open the abdominal cavity and examine the tumor than to use the aspirator. I freely agree with the recommendation that it is better to use the hypodermic needle, if it is desired to obtain the fluid for microscopical examination. But that is not all that we want; where we have a tumor lying in contact with the abdominal wall, where evidence is against its being connected with the ovaries or uterus, and in favor of its connection with the omentum, and where there is fluctuation, it seems to me that in such a case it is justifiable to operate for the relief of the symptoms.

Let me also call attention to the fact that the two patients who were tapped recovered. The first case had some emaciation; the second case had marked emaciation and pronounced cachexia. One of these cases occurred several years ago, and the other several months ago. There is a second point in this connection. It is that we know from pathology that sarcoma invades the system through the bloodvessels and carcinoma through the absorbents. At the same time, it is a curious fact that in the second patient, where the tumor was proven to be sarcomatous, no cachexia was present. The other two cases could not have been due to sarcoma, because they recovered.

The next paper was by DR. HENRY F. CAMPBELL, of Georgia, and was entitled

CONGENITAL FISSURE OF THE FEMALE URETHRA, WITH EXSTROPHY OF THE BLADDER.

After making some general remarks upon abnormalities of the genital organs, and the failure of operations in most cases, he described the following case, which occurred in a little girl, two years old, brought to him by Dr. R. The parents of the child noticed something wrong about the vulva of the child, and called Dr. R.'s attention to it. On examining the patient, he found a red tumor, about the size of a strawberry, at the upper part of the vulva, in the situation of the meatus, and apparently obstructing the passage of the urine. The tumor was very vascular, and evidently constricted, as was shown by its purplish hue. The doctor thought of removing it by a ligature, but, before doing so, resolved to consult Dr. Campbell in regard to it. He saw the case in July, 1880. The tumor presented the appearance above described; but the appearance of the swelling led him to believe that it was composed of the wall of the bladder, and on pressing it, it slipped back, at first slowly and finally suddenly, into the bladder. There was a gush of urine at the moment, but not to any great amount. The upper wall of the urethra presented a flattened appearance, but very little trace of a lateral border, indicating the presence of a cleft. The hymen was perfect, and the posterior commissure and the other parts of the vulva were normal. Careful examination of the symphysis showed that the pubic bones were fully developed.

The whole interest which attaches to this case, beside the rarity of the occurrence, is as regards the proper time to operate. The child is now four years old. There is hardly enough tissue to allow of the necessary paring and bringing together of the parts. He thought that it would be more advisable to operate after puberty, and in the mean time to use such apparatus as will afford the most comfort to the patient.

DR. B. B. BROWNE, of Baltimore, described a somewhat similar case, in which the child died before operation.

DR. M. D. MANN, of Buffalo, related a case which, while not being of the same class of cases as Dr. Campbell's, might throw some light on the point as to the proper time to operate. He had brought to him a girl who had fallen on a broken chair, and produced a laceration of the perineum through the sphincter. He advised an immediate operation. This was performed, and the result was a perfect cure.

DR. CAMPBELL, in concluding, said that his case was an exaggerated hypospadias, and that he thought that the chances of success would be increased by postponing the operation until puberty.

The next paper was by DR. THOMAS ADDIS EMMET, of New York, and was entitled

A STUDY OF THE ETIOLOGY OF PERINEAL LACERATION, WITH A NEW METHOD FOR ITS PROPER REPAIR.

He referred to the fact that for a number of years he had devoted more attention to the subject of laceration of the perineum than to any other in the whole range

of gynecology. It has not been generally recognized that the suffering from lacerated perineum was not in proportion to the extent of the lesion. All have seen cases of severe laceration of the perineum, unaccompanied by symptoms. On the other hand, marked symptoms have followed apparently trivial lacerations. Various modifications of Baker Brown's operation have been employed since he first united the lacerated surfaces, but none of them have done more than relieve the discomfort resulting from the want of unity.

He then described the attachments of the pelvic fascia, and pointed out that the parts above are supported by this fascia. He then referred to a paper which he had presented at the last meeting, describing a transverse laceration of the urethra produced by digital dilatation; the laceration occurred at the sigmoid portion of the urethra where it is surrounded by the pelvic fascia. When the finger reaches this point, the fascia must be put on the stretch or carried forward in front of the finger, and transverse laceration is produced. In a similar way, the head of the child separates the pelvic fascia from the vagina.

In the usual operation for lacerated perineum, it is customary to denude a large part of the surface of the lips on each side. I have seen the denudation carried almost to the level of the urethra. These operations often interfere with sexual intercourse, and if pregnancy occurs, the results of the operation are destroyed. The pain suffered by such an operation is severe.

It is about twelve years since I began to dispose of a rectocele by bringing it up behind the laceration. Observation has shown me that the chief support is obtained in this way. Three years ago I had the opportunity to operate in a case of subinvolution of the vagina. This occurred in a woman aged 35 years. She had had two children. Since the last labor, which occurred a number of years previously, she had suffered from great relaxation of the vagina. There was no rectocele, and no appreciable laceration of the perineum. It seemed as if the running string of the mouth of the bag had been lost. I determined to unite the posterior wall of the vagina, and bring it up behind the perineum at about the former seat of the hymen. The line ran as a crescentic fold across the vagina, and the horns were lost in the sulcus on each side. The dilated vagina was reduced to the size of the vagina in a married woman who has not borne children. After the operation, the line of sutures was entirely within the vagina and out of sight. On passing the finger within the vagina, it was found that the tissues forming the perineum had been drawn up to the pubes.

When the laceration extends to the anus, it is necessary to modify the operation, although the principle is the same. In performing the operation a tenaculum is introduced into each lip at the position of the carunculæ, a third tenaculum catching the posterior wall of the vagina, and these three points are brought together. Traction draws the labial surface upwards and inwards, and reduces the size of the entrance of the vagina. When this procedure is carried out, it is surprising to what an extent the laceration is reduced. Sutures are introduced through the labial surfaces, and a central fold is drawn up to the posterior wall of the vagina. The sutures are first introduced at the angles of the crescentic fold, and alternately on each side. Usually only two or three sutures are required. The most common mistake in performing this operation is made in taking up too much of the posterior wall, the sutures cutting out. In conclusion he gave the following *résumé* of his paper.

Laceration of the perineum does not produce the troubles attributed to it. It is not lacerated as it seems to be. After the laceration, the tissue in front of the rectum may be thicker than it was before the injury.

There is no such body as that which has been termed the perineal body, as has heretofore been taught, and which operators endeavor to build up. This can be proven by any one who puts one finger in the rectum and another in the vagina. He will then find that there is no thick tissue between the fingers.

I hold that even if the lacerated perineum is not restored, you can leave it entirely out of the question, if the posterior wall of the vagina is in contact with the entrance of the vagina where it joins the soft parts.

I hold that we may exclude everything in regard to the external organs of generation, outside of where the hymen runs around the vagina. All sewing together of the outside tissues is a waste of time and structure.

The fascia forming the sulcus on each side of the vagina is all-important in keeping up the perineum and posterior wall of the vagina. It acts just as a pair of suspenders does in keeping up the pantaloons. By bringing a crescentic fold across the vagina, we restore the attachment of the fascia. The perineal trouble can be left entirely out of the question. If the tissues are brought together as I have described, the perineal lesion will be found to be very superficial. The symptom which we attribute to lacerated perineum may be relieved by the operation I have referred to.

Its advantages are that it produces less disturbance of the parts; there is no comparison as to the comfort to the patient between this and the former operation, and the operation is so simple that it may be performed by many men who cannot perform the old operation.

I want to call particular attention to the *rôle* which the fascia plays in supporting these parts, and to the fact that the perineum has little or nothing to do with producing the symptoms complained of.

AFTERNOON SESSION.

The afternoon session began with a discussion of the paper read by Dr. Emmet.

DR. THADDEUS A. REAMY, of Cincinnati, said that he would like to ask Dr. Emmet if he had not seen cases where the only tissue separated was the posterior commissure up to the entrance of the vagina. This injury is purely confined to those parts which Dr. Emmet claims are of no importance. He had another inquiry in regard to the operation. If he understood him rightly Dr. Emmet proposed to leave a surface inside, which was undenuded, which is to be covered over, leaving a cavity. When he described this it reminded him very forcibly of Dr. Sims' operation for cystocele, in which two points on the anterior vaginal wall below the os were denuded, and brought together. This operation was afterwards modified by the distinguished author of the paper just read. The modification consisted in carrying the line of denudation entirely across the vagina, for it was found that in the old operation the cervix settled into the pocket that had been left. It is also a better operation, for the reason that it leaves no cicatrix, but solid, firm union. It seemed to him that if the new operation for lacerated perineum were the better one, that it could be improved by denuding the entire surface.

He supposed that it was customary with every operator where there is great redundancy and prolapse of the posterior wall of the vagina, to close this first and subsequently operate on the perineum; and that everyone has found that in cases where the sphincter is not divided, the same results can be accomplished by taking out the redundant tissue in the posterior wall and including all in one operation.

He thought that the operation which had been de-

scribed was an admirable one for a particular class of cases, but the number of these cases, he believed, was limited. He did not think that it was a substitute for the operation for lacerated perineum.

DR. FRANK P. FOSTER, of New York, said: I think I understand Dr. Emmet to say that the restoration of what is called the perineal body does not contribute to the rectification of the troubles which are complained of. Such being the case, although it is with some hesitation that I do it, I wish to put myself on record as being even more radical. I deny that the perineum has anything whatever to with supporting the uterus under normal circumstances. I think that this doctrine has nothing to recommend it but plausability. I do not think that there is an instance in human anatomy of an organ resting upon anything beneath it. The brain does not rest on the base of the skull, for if the base is removed the brain still remains in contact with the vault of the skull. The heart and lungs do not rest on the diaphragm. The liver rests upon nothing, but is supported from above. The womb does not rest on the perineum any more than it does on the woman's hand. If a healthy woman is examined in the standing position, and the perineal structure is depressed as much as possible, neither the uterus nor the anterior vaginal wall is affected by it. None of the structures that enter into the roof of the pelvis will follow the finger. What the perineum will do, and what it often does, is to sustain a uterus which has lost its normal support from above. The perineum has no sustentative function, but it does not, therefore, follow that the perineum has no function. It serves as a *point d'appui* for a number of muscles.

DR. R. S. SUTTON, of Pittsburg, hoped that he misunderstood Dr. Emmet in saying that no such body as the perineal body exists. He could not believe that he meant to say that there is no such body as the lozenge-shaped body which exists between the rectum and vagina. In frozen sections it is seen to consist largely of connective tissue and muscular fibre. We have been taught that when the perineum is lacerated, the transverse perinei muscles draw the two lips asunder. That is correct, and so long as anatomy stands, we cannot get away from that fact. Dr. Emmet had said that the tissues in front of the rectum are thicker after than before a laceration. He could conceive how the thickness might be greater from the presence of an enormous rectocele, but if there is no rectocele, it is anatomically impossible that the thickness can be greater. It has also been said that the symptoms attributed to the lesion do not necessarily follow it. Dr. Gaillard Thomas has said that a woman had better break her leg than rupture her perineum, and he did not know but that he was about right. He admitted that in many cases symptoms requiring surgical aid do not occur. There are cases of cystocele, of rectocele, and of prolapse of the vaginal walls dragging the uterus down, which have been always attributed to laceration of the perineum, and which as a rule are found only in women who have sustained laceration. Again, when the outlet of the vagina is broken, the vagina becomes a receptacle for atmospheric air, so that when the patient stoops, the air is forced out of the vagina. Such women exhibit a train of nervous symptoms which disappear after the operation.

It has been said that the uterus is not supported by the perineum, or the broad ligament, or the round ligament; and now, if we prove that the peritoneum does not support it, we shall soon be able to show that the uterus is in mid-air, and not supported by anything. It is supported by every thing surrounding it.

If the perineum is of no importance, why is it that laceration of it is followed by cervical catarrh, vaginal catarrh, relaxation of the vaginal walls, and a train of nervous symptoms which are clearly attributable to it? Why is it that in women with partial laceration you almost constantly find anal fissure? In this class of women anal fissure and hemorrhoids occur seven times more frequently than in women who have no laceration.

In reference to the operation just proposed, he can see very clearly how, where the laceration has been limited to the superficial tissues, that it will restore the parts; when the laceration has extended through the perineal centre he cannot believe it. Dr. Sutton then closed by referring to the similarity between this operation and that of Hegar.

DR. EMMET then closed the discussion. He stated that he did not deny the existence of the perineum, but he did deny that there existed any such body as the perineal body. Everything in the pelvis is supported by fascia. He thought that when the members have had an opportunity of reading his paper that they would not see so much to object to in his plan of operation as they now do.

DR. CHARLES CARROLL LEE, of New York, then read a paper on

THE MANAGEMENT OF ACCIDENTAL PUNCTURE AND OTHER INJURIES OF THE GRAVID UTERUS AS A COMPLICATION OF LAPAROTOMY,

in which he gave the details of seven cases of this rare complication, including one that had occurred in his hospital practice. These are all that are known to him in medical literature. From them he drew the following conclusions:

1. The pregnant uterus may be punctured or otherwise wounded during abdominal operations without necessarily causing abortion.

2. Both from *a priori* and clinical evidence, abortion in such cases seems to depend on injury of the uterine contents, not of the womb itself, however severe.

3. If the former has certainly occurred, Cæsarean section is indicated, and should be done at once. In this case, the utmost care must be taken to secure thorough subsequent drainage from the uterine cavity.

4. If the uterine walls alone are injured, the wound is to be treated on general principles. If a deep puncture or incision, it must be sutured with the minutest care, with exact coaptation of the edges. For this purpose, fine silk sutures, rendered antiseptic, are the best. If a nick or superficial puncture, it must not be ligated, for ligatures cut quickly through uterine tissue; if too small to be sutured, the bleeding points must be lightly touched with the thermo-cautery until all oozing has ceased.

Good surgery and the dictates of humanity alike demand that in such circumstances a chance of survival be given the child as well as the mother.

DR. H. P. C. WILSON, of Baltimore, said: I have had some little experience in the closing of wounds of the uterus in laparotomy during pregnancy. Last fall, I performed ovariotomy in a woman four months advanced in pregnancy. The condition was made out before the operation was attempted. On opening the abdomen, it was found that the ovarian tumor had a strong attachment to the uterus. It was found necessary to transfix this adhesion, and tie it in two sections. There were a number of other adhesions to the uterus, the separation of which caused considerable oozing. This was checked by the use of Monsel's solution. The tumor was removed, the pedicle touched with the iron salt, and the abdominal incision closed. This woman did exceptionally well. In two weeks she was sitting up. She then began to have pains in the abdomen, fever and chills. These increased in severity. At the end of a week or ten days, I felt a hard knot in the abdomen, and I was at first disposed to think that I had overlooked a second ovarian tumor; but I finally

concluded that there must be a deep-seated abscess. I was considering whether or not to introduce an exploring needle, when the woman miscarried. This was about three weeks after the operation. The abscess broke at the same time, discharging a large quantity of pus. This abscess gave a great deal of trouble, filling and refilling. It was finally cured by applications of iodine. The patient recovered.

DR. GARRIGUES, of New York, had seen the case described by Dr. Lee, and made some remarks confirming and explaining what Dr. Lee had said.

DR. BYFORD, of Chicago, desired to express his opinion upon some points connected with this subject. First, as to the point of avoiding the danger connected with the operation of ovariotomy, of wounding the uterus. It seems from Dr. Lee's paper that in all cases in which the uterus was wounded, except his own, that pregnancy was suspected, and that consequently there must have been some defect in his examination. In the case which he had, he did not make a thorough examination; he was deterred from making it by the statements that the patient was entirely above suspicion, and he felt that it was not right to subject her to the examination.

The second point is as to our rule of action when the accident has happened. Before hearing this paper, he had concluded that it would always be proper, when the uterus had been wounded, to open the organ and remove its contents. From Dr. Lee's case, he must conclude that an exception to this rule would be favorable. He has reported a case where the contents of the uterus were not removed, and the wound of the uterus was sewed up. In this case pregnancy had probably not advanced beyond three months. At that time the fibres of the organ are not so soft, and they do not tend so strongly to draw open the wound, as at a later period. He thought that if pregnancy had advanced to seven or eight months, that the stitches would not hold. In his own case the wound in the uterus made by the trocar was about the size of his finger. In ten minutes, it was as large as a silver dollar. The traction of the muscular fibres was so strong that he felt convinced that stitches would have been torn out. The plan recommended by Dr. Lee might be used in the early stages of pregnancy; but when the uterus is sufficiently large to cause the kind of traction spoken of, he should be inclined to remove the contents of the organ, even if the wound had not involved its whole thickness.

Another point of the paper seems to be, that in all cases in which the wound was sewed up, the patients recovered, while in all the cases in which it was not closed the patient died. He thought the rule ought to be as he before stated.

DR. LEE said, I have but a few words to add. In regard to Dr. Wilson's case, it does not properly come under the class of cases embraced in this discussion. It was a case in which miscarriage occurred from contiguous inflammation. I should not recommend the application of iron styptics in the pelvic cavity; I think that the thermo-cautery is much safer. I am not disposed to take issue with Dr. Byford in regard to the treatment of wounds of the uterus at early and late periods of pregnancy. It is very probable that at a late period the uterus could not be safely repaired by sutures. One important point in Dr. Byford's case was that the child was viable.

DR. A. REEVES JACKSON, of Chicago, then read a paper entitled,

IS EXTIRPATION OF THE CANCEROUS UTERUS A JUSTIFIABLE OPERATION?

In medical and surgical practice the results obtained from any means or method of treatment are proper tests by which their value may be judged. And, in accordance with this principle, whenever any therapeutic agent has been found, after adequate trial, to generally fail in effecting the purpose of its use, or to be habitually dangerous to health or life, candid and honest men have ceased to employ it.

During the past few years there has been a rapidly growing tendency to a bold, fearless—may I not say reckless?—progressiveness in the surgical branches of our profession that would have appalled our predecessors. When we consider that some of these achievements are scarcely more than ante-mortem examinations, whose chief usefulness consists in demonstrating how long their owners are able to survive the loss of certain bodily organs, we may properly ask whether there is to be any limit to these exhibitions of surgical temerity.

I propose to discuss this question: In view of known facts, is it justifiable to extirpate the uterus for carcinomatous disease?

It is notorious that in almost all instances in which surgical operations have been done for the removal of cancers, they have only been of temporary benefit—if beneficial at all. Nevertheless, so long as these procedures were comparatively free from danger to life; so long as they did no actual harm, they were doubtless proper in many cases, because they added for a time to the patient's comfort. They rarely did more than this. But when the operations themselves become so dangerous as to destroy 70 per cent. of lives within a few hours, or a few days; and when, of the few who escape the operation, 50 to 75 per cent. die from recurrence of the disease within a few months; and when, further, of those who, yet remain all, or nearly all, die as soon as though no operation had been performed, we should halt to consider whether our calling, thus exercised, is beneficial or injurious.

The removal of the whole uterus is not a very novel operation. Andreas A. Cruce removed the organ, per vaginam, for scirrhus in 1560; and similar operations were done by Wrisburg, and by Monteggia at the end of the eighteenth century. Blundell operated in three cases in 1828, two of the patients dying, and one surviving a year, and finally dying from a recurrence of the disease.

In 1878 Prof. W. A. Freund reported a new method, under antiseptic precautions, whereby the uterus could be, as he thought, more safely removed than hitherto. In the early part of 1879 he had operated in ten cases, with the result of five deaths and five recoveries, and in September of that year, at the International Medical Congress, at Amsterdam, he reported four additional cases of his own. In one of these the operation was unfinished; the other three were all fatal. Paggia (*Giornale Internazionale delle Scienze Med.*, fas. 3, 4, 1883) furnishes the latest table of operations by Freund's method. It includes 91 cases; 66 died; 25 recovered; mortality 72.5 per cent. Yet at the London Congress, Freund made the astounding statement that the operation may be undertaken as a not very dangerous one in the early stages of carcinoma and sarcoma, in which it gives promise of a radical cure!

In consequence of the frightful mortality following the abdominal method, Czerny, Schrœder, Martin, and others have practised the removal of the uterus by the vagina, and thus far with better results. A table compiled by Sänger (*Archiv für Gynäkologie*, Berlin, 1883) includes 143 cases, of whom 72 per cent. recovered, and 28 per cent. died.

Extirpation of the uterus for cancer does not save, but destroys life. In order to show how much life has been sacrificed by it, I accept all the known fatal operations as the full number, although it is certain that there have been many more. They amount to

159 cases—97 by the abdominal and 60 by the vaginal method. If we grant that in all these cases the disease affected the cervix, and that the average length of life would be seventeen months, the calculation would show more than 222 years of life—over two centuries—sacrificed by the operation. If we consider that in many of the cases the disease affected the corpus uteri, as it surely did, in which the average duration of life is two and a half years, the aggregate amount of life destroyed would be even greater.

To summarize, I have endeavored to show that

1. Diagnosis of uterine cancer cannot be made sufficiently early to ensure its complete removal by extirpation of the uterus.

2. When the diagnosis can be established, there is no reasonable hope for a radical cure; and other methods of treatment, far less dangerous than excision of the entire organ, are equally effectual in ameliorating suffering, retarding the progress of the disease, and prolonging life.

3. Extirpation of the cancerous uterus is a highly dangerous operation, and neither lessens suffering—except in those whom it kills—nor gives reasonable promise of permanent cure in those who recover. Hence, it fails in all the essentials of a beneficial operative procedure, and should not be adopted in modern surgery.

DR. VAN DE WARKER, of Syracuse, said that in a recent editorial expression of opinion, he took substantially the same ground as that held by Dr. Jackson upon the advisability, as a matter of expediency, of the operation of removing the uterus, as an exemption from suffering and a means of prolonging the life of the patient. Since then he has had no reason to change his views; on the contrary, he had every reason to hold to that view.

After a few general remarks on the value of scraping and the application of the cautery, he described his plan of operating, which is simply the result of carrying Dr. Sims' method to its logical conclusion. Instead of using a solution of five drachms of chloride of zinc to the ounce, he employs a saturated solution. By this plan he has a harmless extirpation of the organ. The uterus is first thoroughly scraped, it is then packed with cotton saturated with Monsel's solution in order to check bleeding; subsequently it is packed with cotton containing the saturated solution of chloride of zinc, the result is an enormous slough of the cavity of the uterus. He exhibited a number of sloughs which had been removed in this way. In one of the cases, while scraping, he found that he was almost in the bladder; he, however, decided to apply the caustic: the result was an enormous opening into the bladder. In about six weeks the opening had contracted to one-quarter inch in diameter, the woman retaining control of the sphincter in the erect position; there was some dribbling when lying down. This patient has just died. The operation was done in January, 1883. One of the specimens had been obtained eighteen months before; the woman was still well. He had operated on eight cases, three of which had since died. He considered it simply to be a question of prolonging life and arresting the downward course of the disease.

DR. EMMET, of New York, said that he had been much pleased with the paper because it expressed his own views in regard to the operation. His experience is limited to one case, and that was unsuccessful. He now disapproves of the operation. About two years ago, a middle-aged, unmarried lady was sent to him with amenorrhœa and nervous symptoms; her family physician had made an examination, and found what he considered to be the remains of an old laceration of the cervix. She denied ever having been pregnant. On examining her, he found the same condition, and felt almost satisfied that the woman had been pregnant. About five days after the first examination, he saw eight or ten minute granulations springing up in the scar, just like wheat in a furrow. In ten days the whole cervix was covered with a mass of epithelioma. On being pressed, she acknowledged that twenty-five years before an abortion had been induced. He determined to remove the womb through an abdominal incision. The operation was a difficult one, but he finally succeeded in removing the entire uterus—the woman had no shock, and the case progressed without trouble for five days. Then came blood-poisoning. He opened the wound in the vagina, and flooded her with water. She died, and he found that, from lying on the back, several ounces of fluid had collected in the hollow of the sacrum, which were not removed by the drainage-tube or washing. If the operation is ever to be done, it should be done by the vagina, and should be confined to removing the uterus for sarcoma.

DR. BAKER, of Boston, said that he had operated in several cases, some so long ago as six years, which have not yet died. By the operation which he performed it is possible to remove the entire supra- and infra-vaginal portions of the cervix, as well as from one-third to one-half of the body of the uterus by a comparatively simple operation. He is sure that he has operated at least thirty times without a single death, and he can recall six cases, of at least five years' standing, which have absolutely recovered.

The operation is as follows: An incision is made at the junction of the anterior wall of the vagina with the cervix, and the dissection is carried up to the level of the internal os in the connective tissue covering the cervix. The same is done on the posterior surface of the cervix. The whole cervix is then removed by a transverse cut. A cone-shaped incision is next made, removing from one-third to one-half of the body of the uterus. The thermo-cautery is then applied to the denuded surface. The advantage of the actual cautery over chloride of zinc is that the patient can be kept absolutely at rest. He is sure that the diagnosis may be made early in these cases, and, if made early, he believes that the diseased tissue can be entirely removed. The cases in which total extirpation is advisable are extremely rare, and comprise those in which the disease begins in the cavity of the uterus.

DR. C. D. PALMER, of Cincinnati, said that, so far as total extirpation of the uterus for cancer is concerned, the cases may be divided into two classes: 1. Those in which it is clearly unjustifiable. 2. Those in which it may be justifiable. The first would include almost every case of cancerous disease beginning in the cervix. The second would include those cases of sarcoma starting in the uterine body, which are very rare. It is usually impossible to determine whether the disease has extended beyond the uterus itself. He has always declined to perform the operation. Last spring he had a case which illustrated the impossibility of determining whether the disease has gone beyond the uterine body. It was a case of soft sarcoma in the body. The infravaginal portion of the neck was free from disease; the womb was freely movable, and no evidence of disease could be detected in the vagina or rectum. He was asked to remove this uterus, but declined. A few days later, he was asked to assist in the removal of a uterus. The case was the same upon which he had declined to operate. With great difficulty the organ was removed, and three small nodules were found in the anterior wall of the rectum and in the connective tissue around the uterus. The woman died in a few hours after the operation. The disease would certainly have returned in a short time.

DR. SUTTON, of Pittsburg, in speaking of the removal of the uterus per vaginam, said that it was not as fatal

as ordinary ovariotomy. Schröder lost only one out of thirteen from the operation. Martin told him that his longest case lived twenty-two months after the operation. He then described the operation as performed in Europe. The woman is placed in the lithotomy position, and Simon's speculum is used to elevate the anterior vaginal wall and depress the posterior. Lateral retractors are also used. In order to prevent the constant presence of blood in the vagina, a stream of carbolized water is thrown in. An incision is made across the cervix, just below the vaginal attachment. A curved needle is then passed through the upper lip of the incision and the ends drawn out together and turned over the pubes. With the thumb-nail everything above the cellular tissue is skinned back until the peritoneum between the bladder and uterus is reached. The incision is then carried across the neck. The posterior lip is then treated in the same way. The peritoneum is then opened and the opening dilated with the finger. A volsellum forceps is next passed through the opening, grasping the fundus and drawing it into the vagina. With a curved needle a double ligature is passed through the broad ligament and firmly tied. A clamp forceps is applied to the ligament, and the ligament cut. The uterus is then drawn down and the ligament on the opposite side is treated in the same way. The opening in the vault of the vagina is not sewed up. Schröder puts a large drainage-tube into the pelvic cavity, one end of the tube being outside of the vulva. The vagina is then packed with cotton saturated with iodoform. Martin sometimes simply stuffs the vagina with antiseptic material, and the patients recover. So far as the advisability of the operation is concerned he had not made up his mind.

DR. JACKSON, in closing the discussion, reaffirmed the conclusions which he had laid down in his paper.

THURSDAY, SEPTEMBER 20TH, THIRD DAY.

BUSINESS MEETING.

The Society assembled at 8.30 A. M., for the transaction of business, with closed doors.

Upon the adjournment of the business meeting it was announced that the following had been elected

OFFICERS FOR THE ENSUING YEAR:

President.—Albert H. Smith, M.D., of Philadelphia.

Vice-Presidents.—James R. Chadwick, M.D., of Boston; S. C. Busey, M.D., of Washington.

Secretary.—Frank P. Foster, M.D., of New York.

Treasurer.—M. D. Mann, M.D., of Buffalo.

Other Members of the Council.—Drs. T. Gaillard Thomas, of New York; Fordyce Barker, of New York; T. A. Reamy, of Cincinnati; R. S. Sutton, of Pittsburg.

It was decided to hold

THE NEXT MEETING

at Chicago, on the last Tuesday in September, 1884.

MEDICAL SOCIETY OF VIRGINIA.

Fourteenth Annual Meeting, held at the Rockbridge Alum Springs, September 4, 5, 6, and 7, 1883.

(Specially reported for THE MEDICAL NEWS.)

(*Continued from page 300.*)

THURSDAY, SEPTEMBER 6TH, THIRD DAY.

AFTERNOON SESSION.

DR. JOSEPH A. WHITE, of Richmond, Va., Surgeon-in-Charge of the Richmond Eye, Ear, and Throat Infirmary, read an interesting report of

CASES ILLUSTRATING DIFFERENT INJURIES OF THE EYE, WITH REMARKS ON INJURIES OF THE EYE AND THEIR RESULTS.

Compression of an eye by a blunt instrument may cause ecchymosis, opacity, with or without inflammatory suppuration of the cornea, rupture of the sclerotic near the sclero-corneal ring, hemorrhage into the anterior chamber or into the vitreous, laceration of the iris, paralysis of the sphincter of the pupil, suspension of accommodation, bursting of the capsule of the lens, stretching or laceration of the zonula of Zinn, and disturbances of the retinal function. If the eye is thrown into violent oscillations, as by concussion, some of these results may follow. Strictly speaking, there can be no such thing as *contre-coup*, so far as effects the eyeball. The damage is usually the result of flattening of the eyeball, the flattening ordinarily occurring in the antero-posterior axis, or at an acute angle to it, and the stretching in the equator or near it, thus stretching apart the sclero-corneal ring, and disarranging the tissues connected with it.

Dr. White then narrated a number of illustrative cases, and made some *Remarks on Stretching of the Zone of Zinn and Dislocation of the Lens.* Injury from compression or concussion of the eye almost invariably results in stretching this suspensory ligament of the lens, and generally results in opacity of the lens, either directly or mediately, through changes effected in the choroid or vitreous. Dislocation of the lens, besides resulting in cataract, often leads to degenerative changes, resulting in cyclitis, with shrinkage of the eyeball or secondary glaucoma, either of which may end in neuralgia or sympathetic disease of the other eye. In this connection, Dr. White reported an illustrative case, and described the operation performed by Dr. Buhl, of Bordeaux, for stretching and rupture of the external nasal nerve or infra-trochlear. A curved incision is made through the skin and subcutaneous tissue at the inner angle of the brow between the pulley of the superior oblique and the tendon of the orbicularis. A strabismus hook is carefully swept closely against the periosteum, and the nerve picked up. This is then separated from its vessels, and by gentle pulling with two pair of flat forceps, one after the other (hand over hand, as it were), it is stretched until rupture takes place. This operation has been performed for persistent ciliary neuralgia, chronic inflammatory and secondary glaucoma, intractable blepharospasm and photophobia, hydrophthalmos, and bids fair to be a great acquisition to eye surgery.

The second class of eye injuries considered are those due to entrance of a foreign body. Small iron filings penetrating the cornea may generally be removed with a magnet. The effect of a foreign body in the eye does not depend so much on its chemical nature or its size, as upon the fact that they are so frequently accompanied by germs of inferior organisms. Experiments have proved that particles of stone, glass, etc., introduced into the anterior chamber do not necessarily cause violent reaction. If they rub against the iris in its movements, then they cause pain and irritation. The same substances introduced into the vitreous humor caused no violent reaction. Iron and copper particles, although exerting a chemical action, do not necessarily induce violent suppurative reaction when introduced into the anterior chamber; but if introduced into the vitreous, sooner or later they cause detachment of the retina, or continual irritation without suppuration, and thus result in sympathetic disturbance of the uninjured eye. Iron does not produce suppuration in the anterior chamber, nor does copper in the vitreous; in the ciliary bodies only a local suppurative action results. Lead does not provoke suppuration anywhere. Metallic

mercury causes inflammatory suppuration in either the anterior chamber or the vitreous.

After discussing at some length the various dominant theories of the manner of development of sympathetic troubles in the sound eye, he passed on to the consideration of the third class of eye injuries—from agents which, by their high temperatures, chemical properties, etc., affect the cornea, conjunctiva, and lids. Scalds, etc., should be treated by first thoroughly cleansing the part with warm water. A strong saccharine solution is useful in removing adhering particles of lime. Threatening iritis is to be warded off by ice-cold compresses. He opposes the local use of lead preparations. Repeated separation of the lids from each other and from the eyeball will prevent adhesions, provided the eschar does not include the cul-de-sac.

The paper concluded with a most interesting detailed account of a case of pulsating exophthalmos, in all probability due to aneurism of ophthalmic artery, with spontaneous cure.

THE REPORT OF THE COMMITTEE ON HYGIENE AND PUBLIC HEALTH,

by DR. W. F. BARR, of Abingdon, Va., stated that nothing had been reported during the past year that was entitled to be termed an advance in this department. "Not even in our own State have any steps been taken to protect 'the people' from charlatans. Year after year have committees labored with the members of the Legislature to induce them to adopt *some* kind of a law regulating the practice of medicine, but all to no effect. Although our neighboring sister States, North Carolina and West Virginia have done good work in this respect, and Illinois, Michigan, Louisiana, and Texas have done likewise, yet in Virginia anybody who can pay the license-tax for the privilege of practising medicine, surgery, etc., can unfurl his banner, hang out his shingle, look wise, and with the assurance of Paracelsus, practise medicine. A good State Board of Health cannot be supported! But when yellow fever, cholera, or smallpox is heard of, some are aroused with a kind of 'graveyard religion,' and are willing for the doctors to labor free of charge to save them from disease and death." The report closed with an urgent appeal to the profession not to "faint in well-doing."

INVITATIONS

were received from the Blue Ridge Springs Company, the Rawley Springs Company, and a renewal of the invitation from the Rockbridge Alum Springs Company for the Society to meet next year at their favorite resorts.

Rawley Springs, Va., was selected as the

PLACE FOR THE NEXT ANNUAL SESSION,

at such time during the summer of 1884 as the Executive Committee might decide upon after conference with the managers of those Springs.

OPIUM HABIT.

THE RECORDING SECRETARY, at the request of Dr. W. G. Rogers, of Charlottesville, Va., who was unable to be present, presented the following preamble and resolutions, which were unanimously adopted:

Whereas, the insidious habit of opium eating is daily increasing—a habit destructive to the health and morality of its victims, and a public calamity that should be abated by all rightful and legal means practicable; and since it is believed that this habit has been favored and increased, and doubtless, too, caused by the indefinite refilling of physicians' prescriptions by druggists, and by the selling of opium and its products in such prescriptions; therefore

Resolved, That we, the members of the Virginia Medical Society, in convention assembled, will use all proper means to prevent the *refilling* of physicians' prescriptions by druggists, whenever these contain opium, its products, or other narcotic poison, by writing upon each prescription "*this shall not be refilled*," or such other methods as may be deemed best to effect the object in view.

2. That we respectfully petition the Legislature of Virginia to enact such laws as will prevent *this evil*, by making it a penal offence for druggists to refill physicians' prescriptions containing opium, or other narcotic poisons, or to sell poisons or other medicines that are recognized as such, without the prescription of a practising physician, which shall not be refilled, but renewed by the physician, as in his opinion needed.

3. That a committee be appointed by the President of this Society to lay these resolutions before the Legislature at its next meeting, with such reasons for the same as may be deemed expedient.

4. That since this question concerns *all the people*, whose welfare and interests are so deeply involved in its solution, in a suppression of the evil, that not only the medical journals, but other papers of Virginia be requested to publish these resolutions.

DR. H. D. KERFOOT, of Manassas, moved that the Committed appointed to petition the Legislature to enact certain medical laws, be continued, looking to a more perfect organization of the

STATE BOARD OF HEALTH,

as also to the establishment of a State Board of Medical Examiners, etc. Carried.

DIPHTHERIA,

the subject for general discussion, was then called up.

DR. RAWLEY W. MARTIN, of Chatham, Va., opened the discussion by reading a paper on

DIPHTHERIA AS IT PREVAILED IN A CERTAIN SECTION IN PITTSYLVANIA COUNTY, VA., IN 1882,

in which he described the general range of the epidemic which so terribly devastated the southern section of this State during the summer and fall of 1882. The epidemic really began during the winter of 1881–82, and spread from a girl who attended a public school in the centre of the infected district. Since 1861, until this time, the disease had not been epidemic. The summer of 1882 was a wet season, and vegetation was unusually luxuriant. The character of the ground consists of a porous soil with a clay substratum. Several instances of direct contagion occurred. In some cases, the throat was so slightly affected as not to be complained of by the children. Among the most unfavorable symptoms were extensive swelling of the lymphatic glands and chest, and profuse epistaxis. Persistent refusal of the child to lie down was another unfavorable symptom. Some were doggedly determined to take nothing by the mouth—not even water, although thirsty. Diphtheritic paralysis was very fatal. Following the epidemic, a wide-spread epidemic of sore throat — not diphtheritic — prevailed throughout the county. The mortality was about one in seven of those attacked with diphtheria. Infants at the breast were seldom attacked. Few adults had the disease. The treatment from the beginning consisted in following the directions given in most of the works on the subject. Tincture of the muriate of iron disordered the stomach, and chlorate of potash locally did no good. Rectal alimentation was the common method of nourishing the children. Full purgative doses of mercury in the outset seemed to modify the trouble. Bichloride of mercury solution (one grain to ℥iv of water) in small doses, say a teaspoonful, acted well. Egg-nog

was also valuable. In fact, alcohol was the one great remedy. From these facts, the Doctor drew the following conclusions:

1. No history of contagion could be satisfactorily traced and it is questionable whether the disease originated *de novo* or not.

2. In this, as in other epidemics, sanitary surroundings had increased the disease-producing properties of the poison germs and rendered the disease more malignant.

3. The disease requires different treatment in different epidemics.

4. That many lives could be saved if treatment could be carried out without resistance from the sufferer.

5. That mercury is not a hurtful remedy, but really seems to possess as much or more power of destroying the disease germs than alcohol.

6. That the disease may exist in the system and at the same time produce very slight sore throat.

7. That the mortality was not greater than is usual in epidemics of like malignancy.

DR. BEDFORD BROWN, of Alexandria, Va., followed in another paper, entitled

REMINISCENCES OF PERSONAL EXPERIENCE IN THE HISTORY OF DIPHTHERIA.

His experience, he said, dates back to 1856, as to diphtheria. Since that time he has seen the disease both in civil and military practice; both sporadic cases and cases belonging to severe epidemics. But treatment has not advanced *pari passu*. He narrated some of the first cases he met with, which prove that they were examples of the true disease; and some of the cases were so complicated with other troubles as to make their detail instructive and interesting. For instance, he speaks of a patient who had hemorrhoids at the time diphtheria attacked him. The infectious disease seized hold of the hemorrhoidal tumors, external and internal, and extensive membranous exudations formed, reaching high up the rectum, which he passed in defecation. Further on, he refers to the fact that no disease has a greater diversity of tendency to death. Thus there is tendency to death by toxæmia from diphtheritic laryngitis, nephritis, suppression of urine, uræmia, reflex paralysis, paresis, inanition, etc. Hence, always watch the route by which death is threatening, and guard with special care, that road. Dr. Brown is a strong believer in the "dual theory" as to the non-identity of diphtheria and membranous croup; arguing his point chiefly from the pathological and etiological standpoints. In his long experience before diphtheria began in his section, some twenty-six years ago, he never saw a case of membranous croup "followed by paralysis of the voluntary or reflex system of nerves." In no case of membranous croup, before diphtheria began in 1856, did he ever witness the kidney troubles that follow diphtheria so frequently. Membranous deposits never occurred on sores or elsewhere on the body, except as a laryngeal membrane before diphtheria was announced. Previous to, and during the process of membranous exudation in croup, the temperature is always high and continuous. On the contrary, who, knowing diphtheria, does not apprehend danger from sudden fall of temperature? Previous to the outbreak of diphtheria in 1856, he never saw in cases of croup, a membranous deposit in the rectum, vagina, or on the vulva, or skin. In diphtheria, the salivary glands often become enlarged; before 1856, he never observed such an effect from membranous croup. Diphtheria is to a greater or less extent infectious. Previous to 1856, he never saw a case of membranous croup that seemed to have the slightest element of infection.

Dr. Brown next referred to the action of diphtheritic poison on the sympathetic and vaso-motor system of nerves. This is chiefly manifested in its paralytic tendency, as shown by paralysis of the heart, stomach, and the digestive organs generally, as also of the kidneys, ending in suppression. Many other well-defined points of difference between diphtheria and membranous croup were brought out.

After this he passed to the *treatment of diphtheria*. Cauterizations are of no service ordinarily. Alum and tannin next came to the front. After their failure to arrest the throat affection, tincture of the chloride of iron was brought into use, and then tincture of iodine —each as a local application. Sulphate of copper and zinc, dissolved in honey and tar-water, then became a popular local remedy. Indeed, almost every conceivable form of astringent, stimulant, alterant, and caustic were resorted to as local applications. The earliest efforts at a *general* treatment of epidemic diphtheria probably consisted in the use of emetics followed by mercurial treatment. Chlorate of potash soon afterwards came into use; then muriated tincture of iron and finally quinia sulphate were added. In mild cases this combination is useful as constitutional remedies, but in addition, alcohol is needed as a nutrient stimulant in severe cases. Belladonna and strychnia have also proved valuable helps. Disinfectants and antiseptics are useful as local applications. Sulphurous, chlorinous, and other like vapors inhaled are serviceable. There are always digestive and assimilative troubles; especially in severe cases are these standing difficulties. In addition to nourishment and cleanliness of the air-passages, he recommends the following local antiseptic:

℞.—Listerine, ... f℥ss.
Cinnamon water, ... f℥iv.
Chlorinated solution of soda, . f℥ss.
Carbolic acid, ... gtt. vj.—M.
S.—Use with syringe or atomizer to throat or nose.

It combines well with the leading vegetable and mineral disinfectants.

For a local application over the salivary and cervical glands, he recommends the application of the following lotion:

℞.—Chloride of ammonium,
Chlorate of potash, . . . āā ℥ij.
Rose water,
Alcohol, ... āā f℥iij.—M.
S.—Apply to the external swelling frequently and freely.

This combination is cooling or refrigerant.

For the hemorrhagic form of diphtheria, Dr. Brown recommends the combined influence of oil of turpentine, ergot, and digitalis internally, and the local spray of dilute Monsel's solution. As an internal disinfectant and tonic,

℞.—Tincture of the chloride of iron, . f℥ij.
Chlorate of potash, . . . ℥j.
Tincture of nux vomica, . . gtt. xx.
Tincture of digitalis, . . . f℥ss.
Water, ... f℥ijss.—M.
S.—Teaspoonful, to a child of two years of age, every one or two hours, in water.

℞.—Hyposulphite of soda, . . ℥ij.
Sulphurous acid, ... f℥iij.
Water, ... f℥ij.
Glycerine, ... f℥j.—M.
S.—Teaspoonful every alternate hour, to be taken with above.

Dr. William Pepper, of Philadelphia, Penna., has written Dr. Brown that he uses, and with encourage-

ment, minute doses of bichloride of mercury and tincture of nux vomica, but Dr. Brown has no experience in the use of this special formula.

DR. WM. SELDEN, of Norfolk, Va., gave the highest recommendation of chlorine water prepared according to *Watson's Practice*, 1st ed. He uses muriatic acid and chlorate of potash to make chlorine, and mixes one-half drachm to four ounces of water, giving one teaspoonful every half-hour, followed by whiskey toddy each time. He had never seen a patient die who was under this treatment. For a local application, he uses alum two drachms, salicylic acid one drachm, sulphur one drachm, with enough glycerine to make the preparation of the consistency of honey. This local and systemic medication is the general Norfolk treatment.

DR. WM. H. COGGESHALL, of Richmond, gave Reiter's theory of diphtheria, which is that the fibrin-destroying function of the liver is not fulfilled as it should be, and hence fibrin accumulates in the blood. Dr. Reiter gives twenty grains of calomel at once, and ten grains every hour, until half an ounce is taken, and claims to cure all cases of the disease.

Session adjourned to 7.45 P.M.

(*To be concluded.*)

CORRESPONDENCE.

PROPER MODE OF REDUCING PARTIAL FORWARD DISLOCATION OF THE STERNO-CLAVICULAR JOINTS.

To the Editor of THE MEDICAL NEWS.

SIR: The following letter of Prof. Cabell came too late to enable me to utilize it for the recent edition of my *Surgery*, and I therefore send it to THE NEWS, as I consider it too valuable to be lost. Yours truly,

S. D. GROSS.

DEAR DR. GROSS: If that part of the forthcoming edition of your *Surgery* which treats of Dislocations has not already been put to press, I wish to avail myself of your courteous offer, and to invite your attention to the particular features and treatment of a *partial* forward dislocation of the clavicle at its sternal extremity. I call it *partial*, as coinciding with the probable integrity of the costo-clavicular or rhomboid ligament, although in respect of the degree of displacement it may be fully as complete as any ordinary dislocation at this joint.

The costo-clavicular ligament is not a part of the proper articular apparatus of the sterno-clavicular joint, and yet its integrity or its rupture may very materially modify the indications in respect of the retentive means after a reduction of the dislocation. In order to reduce and retain the articular end of the clavicle in place, it is directed to carry the shoulder backwards, and maintain it in that position by such an apparatus as is used for fractures of the bone. This is doubtless correct in all those cases in which the costo-clavicular ligament is torn, but I have seen two cases in which the act of carrying the shoulder backwards greatly aggravated the forward displacement of the sternal end of the clavicle, and in which the dislocation could only be reduced by bringing the shoulder far forward; in other words, the clavicle moved exactly as it does in the normal mechanism of its movements—namely, as a lever of the first kind. The sternal end recedes as the shoulder comes forward, and *vice versa*. It is presumable that the fulcrum, during the execution of these normal movements, is at the costo-clavicular ligament, and that when this is completely torn up, the leverage action is destroyed. In such a case, the whole bone would have to be carried backwards in order to effect the return of the sternal end from its forward displacement; but if the fulcrum remains, then the shoulder has to be brought forward in order to carry the sternal end of the clavicle back into its proper place. Certainly this was found to be necessary in the two exceptional cases to which I have alluded.

That this is a more common occurrence than is supposed I think exceedingly probable, for some writers, notably Bryant, speak of the difficuly of keeping the articular end of the clavicle in place after reduction without forcible pressure directly applied. I think it probable that in some of these cases the difficulty would have been lessened by advancing the shoulder.

Very truly yours, J. L. CABELL.

UNIVERSITY OF VIRGINIA,
June 12, 1882.

NEWS ITEMS.

ATLANTIC CITY, N. J.

(*From our Special Correspondent.*)

ATLANTIC CITY has at length accepted the views of the State Board of Health of New Jersey and of very many Philadelphia physicians, as to the necessity of sewerage. It has contracted with a company which, by means of approved sewers, will carry all fouled liquids to a pumping station outside of the city limits, from which it will be conveyed, by means of a force-pump, three or four miles away, and then filtered and precipitated so as to form a compost and to leave clear water. With this and its excellent water supply the city will have secured the first essential conditions of a health resort by the sea.

TYPHOID FEVER IN NEW YORK.—According to the records of the Board of Health, typhoid fever has alarmingly increased in New York during July and August, and this increase will continue as cold weather sets in, and the city fills up with people from the country. A map of the cases, so far as prepared, does not show that the disease is confined to any particular locality, but is rather distributed generally over the city among those who do not avail themselves of early medical advice.

The Board calls attention to the neglect of proper disinfection in typhoid fever, as is shown in the reports of their inspectors. In several instances already, where there were no sanitary defects to account for it, five or six cases have occurred in one family. In these instances it has been found that the undisinfected excreta of the patients have been left for hours in the room where the sick and well have been together. The physician is often not called in until the disease has progressed into the diarrhœal stage, and the family are often unable to secure his continual services. He sometimes contents himself with advising disinfection, in a general way, without particularizing as to quality or method. It is no uncommon thing to find saucers filled with chloride of lime in one corner, and a pile of stained and infected bedclothes in another. It is of little use to empty a privy or repair a broken sewer if the sick-room itself is neglected. The vital point in the sanitary treatment of typhoid fever is the efficient disinfection of the clothing, bedding, and discharges of the patient, and this is considered to be an important factor in controlling the disease during the approaching winter.

The Board has issued an address to the public in which the importance of disinfection is insisted upon.

In this connection, we may refer our readers to our Special Article on the subject of typhoid disinfection

which appeared in the issue of THE MEDICAL NEWS for September 1, 1883, page 244.

YELLOW FEVER AT PENSACOLA.—No case of yellow fever has appeared in the city of Pensacola, the disease having been confined to the Naval Reservation.

During the past week there have been reported at the Navy Yard eleven new cases of fever and one death.

YELLOW FEVER AT HAVANA.—There were one hundred and fifty-two deaths from yellow fever at Havana during the month of August. During the week ending September 7th there were eighteen deaths from the same cause.

YELLOW FEVER AT VERA CRUZ.—At Vera Cruz there were nineteen deaths from yellow fever during the ten days from August 20th to 30th.

YELLOW FEVER IN MEXICO.—Surgeon-General Hamilton, of the Marine-Hospital Service, has information from Yuma, Arizona, of the existence of yellow fever in Guayamas and Mazatlan, in Mexico. He says, however, there is no reason for fear that the disease will spread into Arizona, and from his information as to the character of the country, and the climatic conditions of the region in Mexico in which the disease has appeared, he does not think it will spread much there.

Later reports state that the disease is abating at Guayamas.

SANITARY INSPECTION OF THE MISSISSIPPI.—Secretary J. H. Rauch has issued the following:

"The Executive Committee of the Sanitary Council of the Mississippi Valley hereby gives notice that its supervision of inspection at the port and in the city of New Orleans, and the inspection stations below Vicksburg, at Fort Adams, Miss., and below Memphis, at President's Island, Tenn., will be discontinued on and after Saturday, September 15th."

SMALLPOX IN NEW ORLEANS.—For the week ending September 8th, there were eight cases of smallpox in New Orleans.

THE MORTALITY IN NEW JERSEY.—The State Board of Health of New Jersey reports a marked decrease of mortality for the year ending July 1, 1883.

LEPROSY AT SAN FRANCISCO.—A case of leprosy was brought to San Francisco by the last steamer from Honolulu. The quarantine officers refused permission for him to land. A writ of habeas corpus has been issued, and the matter will come up in the Superior Court for decision.

BEST METHOD OF TESTING MILK.—DR. E. H. BARTLEY, Chemist of the New York State Board of Health, recently delivered a lecture to the milk-dealers of Brooklyn, in which he said that milk which showed a specific gravity of 100, at a temperature of 60° by the common lactometer, and 10 per cent. of cream by the cream gauge, could be safely sold as pure milk.

AMERICAN ACADEMY OF MEDICINE.—The annual meeting of the Academy will be held at the New York Academy of Medicine October 9th and 10th.

DEATH OF ONE OF THE FRENCH CHOLERA COMMISSIONERS.—Dr. Thuillier, a member of the Pasteur Scientific Mission, died at Alexandria on Tuesday, the 18th inst., of cholera.

PROFESSOR MATTHEW HAY.—DR. MATTHEW HAY, late assistant to the Professor of Materia Medica in the University of Edinburgh, has recently been appointed to the Chair of Medical Jurisprudence in the University of Aberdeen, rendered vacant by the resignation of Prof. Ogston.

"HOSPITAL SATURDAY" IN LONDON.—On September 1st, collections were made in London and the suburbs for what is known as the "Hospital Saturday Fund." The collection was made in two ways. Money-boxes, which were in many cases in charge of ladies, were placed at the corners of streets, near coffee palaces, and at other places where there were likely to be large crowds of people. There were twelve hundred ladies thus engaged in various parts of London. A collection was also made in the workshops of the capital by means of subscription sheets.

There is every reason to believe that the collections will considerably exceed in amount those of last year. It is thought that the street collection will produce at least £3000, and the workshop collection £7000.

NEPHRECTOMY IN BIRMINGHAM.—On August 11th, MR. BENNETT MAY, excised the right kidney of a female patient, æt. 24, at the Queen's Hospital, Birmingham. The organ, which was the seat of tubercular disease, and weighed nearly a pound, was removed by lumbar incision. No urine was secreted after the operation, but, with this important exception, there was little indication of local or constitutional disturbance till the patient's death, which occurred suddenly five days afterwards. The necropsy showed, as the suppression of urine indicated too surely, that the other kidney was also disorganized by similar disease.—*British Med. Journal*, Sept. 1, 1883.

HEALTH IN MICHIGAN.—Reports to the State Board of Health for the week ending Sept. 8, 1883, indicate that consumption, influenza, neuralgia, and puerperal fever have decreased in area of prevalence.

Compared with the average for the month of August in the preceding six years, remittent fever was considerably less prevalent; intermittent fever, dysentery, consumption, and whooping-cough less prevalent, and bronchitis and neuralgia more prevalent during August, 1883.

Including reports by regular observers and by others, diphtheria was reported present during the week ending Sept. 8, and since, at fourteen places, scarlet fever at twelve places, and measles at four places.

OFFICIAL LIST OF CHANGES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM SEPTEMBER 10 TO SEPTEMBER 17, 1883.

BARTHOLF, JOHN H., *Captain and Assistant Surgeon.*—Station changed from Fort Lapwai, I. T., to Vancouver Barracks, W. T.—*Par. 2, S. O. 123, Department of the Columbia, September* 6, 1883.

BANISTER, J. M., *First Lieutenant and Assistant Surgeon.*—Assigned to duty at Fort Adams, R. I.—*Par. 3, S. O. 170, Department of the East, September* 10, 1883.

THE MEDICAL NEWS *will be pleased to receive early intelligence of local events of general medical interest, or of matters which it is desirable to bring to the notice of the profession.*

Local papers containing reports or news items should be marked.

Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.

All communications relating to the editorial department of the NEWS *should be addressed to No. 1004 Walnut Street, Philadelphia.*